

07737

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>15</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W Hyattsville</b> d. STREET ADDRESS <b>7405 18th Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Girl Allbright</b>				4. DATE OF DEATH Month Day Year <b>July 16 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 July 1957</b>	
9. AGE (In years last birthday) yrs. <b>2</b> Months <b>30</b> Days <b>30</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>Franklin Love Albright</b>			
14. MOTHER'S MAIDEN NAME <b>Yvonne Camille Bourguignon</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> <b>762.5</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> (c) <b>Prematurity</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prematurity</b> INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 15, 1957</b> , to <b>July 16, 1957</b> , that I last saw the deceased alive on <b>July 16, 1957</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Puckin</b>				DATE SIGNED <b>7/16/57</b>			
PHYSICIAN'S NAME (Type) <b>John W. Puckin</b>				M.D. <b>5301 Hamilton St. Hyattsville</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>July 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince Georges Lutheran Church</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Puckin</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 22 '57</b>			
24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>				24c. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. JOHN'S COLLEGE, NEW YORK

JUL 22 1957

RECEIVED

(7798

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hill Crest HTS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hill Crest HTS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>15012-25th Pl. Hillcrest HTS</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>IRVING</u> Last <u>ARCHER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1877</u>	9. AGE (In years last birthday) <u>80</u> yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Washington Irving Archer</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Woolcott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Cardiovascular Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>57</u> , to <u>7/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/5</u> , 19 <u>57</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Leonarduzzi</u> M.D.				ADDRESS (Street, city or town, state) <u>2901 Fairlawn St SE</u>			
DATE SIGNED <u>7/5/57</u>				PHYSICIAN'S NAME (Type) <u>David Leonarduzzi</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colman Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Tom. Lee Sons</u> ADDRESS <u>4th &amp; Main ave. N.E.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Overhill</u>	
DATE <u>JUL 8 57</u>							

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RECEIVED



07738

CERTIFICATE OF DEATH

07723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. LENGTH OF STAY IN 1b <b>8 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>3210 Upshur St.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Arnold</b>		4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1899</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Wiltz Miller</b>		14. MOTHER'S MAIDEN NAME <b>Sarah ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Henry Arnold</b> Address <b>Mt Rainier, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction - Cerebral/renal</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/19/57</b> 19 <b>57</b> , to <b>7/21/57</b> 19 <b>57</b> , that I last saw the deceased alive on <b>7/21/57</b> 19 <b>57</b> , and that death occurred at <b>7:13 P</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>W. E. Weintraub</b>		M.D. <b>30 C Ridge Rd. Greenbelt, Md.</b>		DATE SIGNED <b>7/21/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. William Weintraub</b>		<b>Greenbelt, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/24/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Park Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 26 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Weintraub</b>	

# CERTIFICATE OF DEATH

67733

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
JULY 26, 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		ATTORNEY		HIGH SCHOOL	
TIME OF DEATH		HOURS		MINUTES		SECOND		TEMPERATURE		PULSE	
10:00 AM		10		00		00		98.6		60	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JUL 26 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 628 7-19-57 et

## CERTIFICATE OF DEATH

07724

07739

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CARMODY HILLS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GEN. HOSP.</b>				d. STREET ADDRESS <b>218 FRANKLIN DR.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BENEDEK</b> Middle <b>AUGUSTINE</b> Last <b>AUGUSTINE</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 19, 1881</b>	
9. AGE (In years lost birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Phila Bakery Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Hungary</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>John W Augustine</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Seplock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212 18 2324</b>		17. INFORMANT <b>Bertha Augustine Carmody Hills Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Carcinoma of the Prostate with metastases</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>24 hours</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.1</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/9, 19 57</b> , to <b>7/11, 19 57</b> , that I last saw the deceased alive on <b>7-11, 19 57</b> , and that death occurred at <b>10:50 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William C. Weintraub</b>		M.D.		ADDRESS (Street, city or town, state) <b>30 C Ridge Rd Bethesda</b>		DATE SIGNED <b>7/11/57</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM C. WEINTRAUB</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 13, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Smithland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Sarris Sons</b>				ADDRESS <b>Hyattsville, Md</b>		24a. REC'D BY REGISTRAR <b>DATE Jul 15 57</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. C. Leach</b>			

RECEIVED

BUREAU V. S.

07740

## CERTIFICATE OF DEATH

07725

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 Hrs 15 Min 15		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS / 7400 85th Ave.,		4. DATE OF DEATH Month July		Day 13		Year 19 57	
3. NAME OF DECEASED (Type or print) First Robin		Middle Bageant		Last Bageant		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-22-52		9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Harris Bageant		14. MOTHER'S MAIDEN NAME Janice Nadine Pleasants		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INTERSTITIAL PNEUMONIA (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 15 hrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 517X FPIGLOTTIC EDEMA. (TRACHEOTOMY PERFORMED)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cheverly		(County) Cheverly		(State) Md.	
21. I certify that I attended the deceased from 7/1/57, 1957, to 7/13/57, 1957, that I last saw the deceased alive on 7/13/57, 1957, and that death occurred at 8:45P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cheverly Ave Cheverly Md.		DATE SIGNED 7/14/57		ACTUAL SIGNATURE John Kehoe M.D.		PHYSICIAN'S NAME (Type) Dr. John Kehoe		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF July 16, 57		22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) Falls Church Va.		22e. (State) Va.		23. FUNERAL DIRECTOR'S SIGNATURE Frances Meschis Sons		ADDRESS 7 Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE JUL 16 57		24b. REGISTRAR'S SIGNATURE A. J. Keen		24c. (City, town, or county) Cheverly		24d. (State) Md.		24e. (County) Cheverly		24f. (State) Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
George Washington		Male		45		1910		Baltimore, Md.		Physician		Heart Disease		Home		July 15, 1957		5:00 PM		J. A. Smith		J. B. Jones	
13. HUSBAND'S NAME		14. WIFE'S NAME		15. CHILDREN		16. EDUCATION		17. RELIGION		18. MARITAL STATUS		19. PREVIOUS ILLNESS		20. PREVIOUS SURGERY		21. PREVIOUS TRAUMA		22. PREVIOUS DRUGS		23. PREVIOUS ALCOHOL		24. PREVIOUS TOBACCO	
None		None		None		High School		Catholic		Married		None		None		None		None		None		None	
25. PREVIOUS MENTAL ILLNESS		26. PREVIOUS PHYSICAL ILLNESS		27. PREVIOUS TRAUMA		28. PREVIOUS DRUGS		29. PREVIOUS ALCOHOL		30. PREVIOUS TOBACCO		31. PREVIOUS OTHER		32. PREVIOUS OTHER		33. PREVIOUS OTHER		34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None	

RECEIVED  
JUL 16 1957  
BUREAU V. 3



(7799)

CERTIFICATE OF DEATH

07720

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN 1b 5 yrs., 6 mos., & 26 days		d. STREET ADDRESS 1405 E. Capitol St.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George H. Barbour		4. DATE OF DEATH Month Day Year 7 26 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/77
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Capitol Wallpaper Co.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Barbour		14. MOTHER'S MAIDEN NAME Ella Eagan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. --	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Pulmonary tuberculosis, 6 yrs.,			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/31/1951, to 7/26/57, 19, that I last saw the deceased alive on 7/26/1957, and that death occurred at 12:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Moe Weiss Glenn Dale Hospital 7/26/57 ACTUAL SIGNATURE M.D. Glenn Dale, Md. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Type)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. H. Lee		ADDRESS Wash. D. C.	
24a. REC'D BY REGISTRAR DATE JUL 30 57		24b. REGISTRAR'S SIGNATURE C. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

JUL 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07726

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GEN. HOSP.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>NEW JERSEY</b> b. COUNTY <b>FANWOOD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>67x.3</b> d. STREET ADDRESS <b>191 LE GRANDE AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERALDINE</b> Middle <b>BARTHOLOMEW</b> Last <b>JULY</b>		4. DATE OF DEATH Month <b>12</b> Day <b>19</b> Year <b>57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-10-04</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>12</b> Hours <b>19</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Atlantic City, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Maloney</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Mac Sweeney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>184018 Broad St. Philadelphia</b>	
17. INFORMANT <b>Joseph Maloney, Jr., Pa.</b>		Address <b>184018 Broad St. Philadelphia</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of BREAST (Left)</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Secondary Metastatic Tumors Skeletal Structures</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/26/1957</b> to <b>7/12/1957</b> , that I last saw the deceased alive on <b>7/12/1957</b> , and that death occurred at <b>5:00P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Albert Roth</b> <b>7-12-57</b>			
ACTUAL SIGNATURE <b>Albert Roth</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Dr. Albert Roth</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colonar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Valley's Funeral Home, Inc.</b>		ADDRESS <b>Mt. Rainier, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE JUL 16 57</b>		24b. REGISTRAR'S SIGNATURE <b>Art. Smith</b>	

# CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

For use by

DATE OF DEATH

STATE

COUNTY

WITNESS

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SIGNATURE OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

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PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

BUREAU V. S.

JUL 16 1957

RECEIVED

07742

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEO.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHAEVERLY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SEA BROOK ACRES</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEO HOSP</b>		d. STREET ADDRESS <b>19513 WELLINGTON</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EUNICE H. BENTON</b>		4. DATE OF DEATH Month Day Year <b>July 19 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 13 1912</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S GOV</b>	
11. BIRTHPLACE (State or foreign country) <b>Ill</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY L. TIDEMAN</b>		14. MOTHER'S MAIDEN NAME <b>ELLA PERSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>CHARLES E BENTON</b>		Address <b>P.O. Box 264</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>416X</b> DUE TO <b>Ventricular Fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonic Heart Disease</b> (c) <b>10 min</b> <b>10 min</b> <b>20 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>10 min</b> <b>20 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.1</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 17</b> , 19 <b>57</b> to <b>July 19</b> , 19 <b>57</b> that I last saw the deceased alive on <b>July 17</b> , 19 <b>57</b> , and that death occurred at <b>1:15</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>17416 K Street NW Washington D.C.</b> DATE SIGNED <b>7/19/57</b>			
ACTUAL SIGNATURE <b>William T. Gill Jr.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>William T. Gill Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-22-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deaf Funeral Home</b>		ADDRESS <b>4812 H. Ave NW</b>	24a. REC'D BY REGISTRAR DATE <b>JUL 22 57</b>
		24b. REGISTRAR'S SIGNATURE <b>Wheeler</b>	



RECEIVED

JUL 22 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MISSOURI STATE DEPARTMENT OF HEALTH - BULLETIN 19



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07728

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camden</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>607 Liberty Street</b>		67X-3	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Ronald Louis Blackwell</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>July 7 19 57</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>colored</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-15-39</b>	
<b>9. AGE</b> (In years last birthday) <b>17</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>N. J.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Ronald L. McNair</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Hazel Blackwell</b>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Currently</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>U.S. Navy Records</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Crushed chest and abdomen</b> DUE TO (c)							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in an automobile in collision with a tractor-trailer.</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>6.10</b> p. m. <b>7-7-</b> <b>1957</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		<b>20f. (City or town) (County) (State)</b> <b>Contee Pr. Geo. Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>DATE SIGNED</b> <b>July 7, 1957</b>				<b>22a. REC'D BY REGISTRAR</b>			
<b>22b. DATE THEREOF</b> <b>7-11-57</b>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>National Cemetery</b>			
<b>22d. LOCATION (City, town, or county) (State)</b> <b>Beverly, New Jersey</b>				<b>24a. REC'D BY REGISTRAR</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Robert Snowden-Rockville, Md.</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <b>DATE JUL 12 57</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Indigastl Indigastl 2000 2000

## Diagrams

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• *Yellow* • *White*

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RECEIVED  
JUN 12 1957

[illegible]

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. *24x*FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <i>47x-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route # 4 and Suitland Parkway</b>			d. STREET ADDRESS <b>3421 21st Street S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>John Werden Blake</b>			4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>19 57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1931</b>		9. AGE (In years last birthday) <b>25</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	
13. FATHER'S NAME <b>Noah M. Blake</b>			14. MOTHER'S MAIDEN NAME <b>Violette Onque</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 1953-1956</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Violette Onque, smae as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> <i>823x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Crushed chest and abdomen, fracture of the base of skull</b> DUE TO (c) <b>Compound comminuted fractures of both legs</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Diver of car that ran off road and struck a tree</b>			
20c. TIME OF INJURY Month, Day, Year <b>7/8 19 57</b> Hour <b>1:15</b> o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route # 4</b>	
		20f. (City or town) <b>Forestville P. G.</b>		(County) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James I. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>July 8, 1957</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7.22.57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cemetery</b>	
		22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert M. McKie</i>		ADDRESS <b>1820-9th St. WASH. D.C.</b>		24a. REC'D BY REGISTRAR <b>Jul 11 1957</b>	
		24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Deceased's Name: [illegible]  
Residence: [illegible]  
Date of Birth: [illegible]  
Sex: [illegible]  
Race: [illegible]  
Occupation: [illegible]  
Cause of Death: [illegible]  
Manner of Death: [illegible]  
Place of Death: [illegible]  
Date of Death: [illegible]  
Time of Death: [illegible]  
Signature of Medical Examiner: [illegible]  
Signature of Coroner: [illegible]

Examination of chest and abdomen, interior of the base of skull  
Examination of internal organs of body  
Examination of chest and abdomen, exterior of the base of skull  
Examination of internal organs of body

**RECEIVED**  
JUL 11 1957  
**BUREAU V. 2**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG218 8-7-57 et

07730

07801

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills</u>		c. LENGTH OF STAY IN 1b <u>?</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills</u> X2		d. STREET ADDRESS <u>5744 FIRST ST</u> 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>KATHERINE</u> First <u>B</u> Middle <u>BRADLEY</u> Last				<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>29</u> Year <u>1957</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4-5-1873</u>	
<b>9. AGE</b> (In years last birthday) <u>84</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>N.J.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Thomas Melville</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>?</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Charles Bradley</u> Address <u>5010 Lagona Co. College PK. Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)				<b>20g. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>7-28</u> <u>1957</u> , to <u>7-29</u> <u>1957</u> , that I last saw the deceased alive on <u>7-29</u> <u>1957</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>David J. Gordon</u> M.D.				<b>ADDRESS</b> (Street, city or town, state) <u>5731 23rd Parkway</u>			
<b>PHYSICIAN'S NAME</b> (Type) <u>David J. Gordon</u>				<b>DATE SIGNED</b> <u>Wash. 21. D.C.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>22b. DATE THEREOF</b> <u>8/1/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>bedon Hill</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Therese Hannon</u>				<b>ADDRESS</b> <u>3831 La Grille</u>		<b>24a. REC'D BY REGISTRAR</b>	
<b>24b. REGISTRAR'S SIGNATURE</b>				<b>DATE</b>			



BUREAU V. S.

AUG 2 1957

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7800

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07731

Reg. Dist. No.

Item 3: G218 7/15/57

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Erie</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adephi</b>		c. LENGTH OF STAY IN 1b <b>7 hrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Erie</b> <b>75X-3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8602 21st. Place</b>			d. STREET ADDRESS <b>240 West 11th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>William</b> Last <b>Brogan</b> <b>Ralph</b>			4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>19 57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, '09</b>		9. AGE (In years last birthday) <b>48</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>John Brogan</b>			14. MOTHER'S MAIDEN NAME <b>Anna Nicholas</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Harriet Ann Brogan</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular disease</b> (c) <b>434.1</b> DUE TO cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John J. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>July 14, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation</b>		22b. DATE THEREOF <b>7/15/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Summerville</b>	
22d. LOCATION (City, town, or county) <b>Pennsylvania</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 16 '57</b>	
				24b. REGISTRAR'S SIGNATURE <b>R. Gasch</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Name of Deceased: John T. Taloney, Jr. Date: July 16, 1957

Age: 35 Sex: Male Race: White

Place of Birth: St. Louis, Mo. Date of Birth: July 22, 1922

Occupation: Transportation Education: High School

Marital Status: Married Name of Spouse: Anna M. Taloney

Place of Residence: Baltimore, Md. Date of Death: July 16, 1957

Signature of Physician: John T. Taloney, Jr. Signature of Medical Examiner: John T. Taloney, Jr.

Signature of Coroner: John T. Taloney, Jr. Signature of Registrar: John T. Taloney, Jr.

Signature of Burial Director: John T. Taloney, Jr. Signature of Undertaker: John T. Taloney, Jr.

Signature of Funeral Home: John T. Taloney, Jr. Signature of Cemetery: John T. Taloney, Jr.

Signature of Interment: John T. Taloney, Jr. Signature of Burial: John T. Taloney, Jr.

Signature of Burial: John T. Taloney, Jr. Signature of Burial: John T. Taloney, Jr.

Signature of Burial: John T. Taloney, Jr. Signature of Burial: John T. Taloney, Jr.

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Signature of Burial: John T. Taloney, Jr. Signature of Burial: John T. Taloney, Jr.

**RECEIVED**  
JUL 16 1957  
BUREAU V. S.

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07732

1. PLACE OF DEATH a. COUNTY <b>Pr. Geo. County</b> <b>07803</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takeland</b> c. LENGTH OF STAY IN 1b <b>x2</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8111 51st Avenue</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>P. G. Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lakeland</b> d. STREET ADDRESS <b>8111 51st Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Joseph</b> Last <b>Brooks</b>		4. DATE OF DEATH Month <b>7</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>85</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Robertson</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Robertson</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>1507 C Street, S. E. (D C.)</b>	
17. INFORMANT <b>Joseph Brooks - son</b>		Address <b>1507 C Street, S. E. (D C.)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month <b>10</b> Day <b>15</b> Year <b>1956</b> Hour <b>8</b> P.M.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	20f. (City or town) <b>None</b> (County) <b>None</b> (State) <b>None</b>
21. I certify that I attended the deceased from <b>10-15-56</b> to <b>7-19-57</b> , that I last saw the deceased alive on <b>7-19-57</b> , and that death occurred at <b>8 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1901 11th Street, N. W. Washington, D. C.</b> DATE SIGNED <b>7-19-57</b>			
ACTUAL SIGNATURE <b>J. C. Oliver, MD</b>		M.D. <b>1901-11th St. Wash D.C.</b>	
PHYSICIAN'S NAME (Type) <b>J. C. Oliver, MD</b>		<b>1901 11th Street, N. W. Washington, D. C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-23-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, P.G. Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Alexander S. Pope, Jr.</b>		ADDRESS <b>414 15th St., S. E.</b>	
24a. REC'D BY REGISTRAR <b>DATE 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>	

CERTIFICATE OF DEATH

<p>1. Name of Deceased: <u>John A. Smith</u></p>		<p>2. Date of Death: <u>July 28, 1957</u></p>	
<p>3. Place of Death: <u>Home</u></p>		<p>4. Age: <u>65</u> Years</p>	
<p>5. Sex: <u>Male</u></p>		<p>6. Race: <u>White</u></p>	
<p>7. Cause of Death: <u>Heart Disease</u></p>		<p>8. Immediate Cause: <u>Myocardial Infarction</u></p>	
<p>9. Contributing Cause: <u>None</u></p>		<p>10. Manner of Death: <u>Natural</u></p>	
<p>11. Signature of Physician: <u>[Signature]</u></p>		<p>12. Signature of Registrar: <u>[Signature]</u></p>	
<p>13. Date of Entry: <u>July 29, 1957</u></p>		<p>14. Office: <u>Baltimore</u></p>	

BUREAU V. R.

JUL 29 1957

RECEIVED

07804

## CERTIFICATE OF DEATH

Reg. Dist. No.

07733

283

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>			
c. LENGTH OF STAY in hospital <u>11 months &amp; 4 days</u>				d. STREET ADDRESS <u>1229 3rd St., SW, Apt. 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Douglas</u> Middle <u>—</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>7</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/10</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>10th &amp; D. Sts., SW</u>			11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>USA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Henry Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mattie ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>579-12-8734</u>		17. INFORMANT <u>Decedent</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis of both lungs, primary site /</u> <u>undetermined</u> <u>1999</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X Pulmonary tuberculosis, 1 yr.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>8/13</u> , 19 <u>56</u> , to <u>7/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/16</u> , 19 <u>57</u> , and that death occurred at <u>12:30AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>7/17/57</u>							
ACTUAL SIGNATURE <u>Moe Weiss</u>		M.D. <u>Glenn Dale, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>		Glenn Dale, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>7/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Phinen + Co.</u>		ADDRESS <u>901 3rd St SW</u>		24a. REC'D BY REGISTRAR <u>MIL 19 57</u>	24b. REGISTRAR'S SIGNATURE <u>Phinen</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 19 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07734

Reg. Dist. No. 243

FOR STATE  
HEALTH DEPT.

07744

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale Maryland</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 College Park, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>4320 Rowalt Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Estelle Gormley Brucker</b>			4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1957-19</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 5, 1906</b>		9. AGE (In years last birthday) <b>51</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U S Government</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Navy Yard Naval Gun factory</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
13. FATHER'S NAME <b>William D. Gormley</b>			14. MOTHER'S MAIDEN NAME <b>Lida Robinson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>James R. Gormley</b> Address <b>1318 Saratoga Avenue N E Washington D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO (b) <b>2nd and 3rd degree burns of 40 % of body</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>and inhalation of smoke.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>916.0</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Conflagration in home</b>			
20c. TIME OF INJURY Month, Day, Year <b>4.15</b> Hour <b>7-8-</b> o. m. <b>19 57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>College Park, Pr. Geo. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>7/11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>
			22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>7/12/57</b>
			24b. REGISTRAR'S SIGNATURE <i>James R. Gormley</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

JUL 12 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07805

## CERTIFICATE OF DEATH

07735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's. Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oaklawn</b>				c. LENGTH OF STAY IN 1b <b>13 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oaklawn</b>			
d. STREET ADDRESS <b>6138- Oaklawn Road S.E.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>A.</b> Last <b>BURLILE</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15th</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 27- 1876</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>		11. BIRTHPLACE (State or foreign country) <b>Ross Co. Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Jerry Burlile</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Barnhart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Nellie M. Burlile</b>				Address <b>6138 -Oaklawn Rd. S.E.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-Sclerotic Heart Disease c</b> DUE TO <b>Myocardial Degeneration</b> (c) <b>Myocardial Degeneration</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>610X</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b> <b>5 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec. 16, 1952</b> , to <b>July 15, 1957</b> , that I last saw the deceased alive on <b>July 15, 1957</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7519 Broadview Rd S.E.</b> DATE SIGNED <b>7/15/57</b> ACTUAL SIGNATURE <b>Anna Coyne Todd</b> M.D. <b>7519 Broadview Rd S.E.</b> PHYSICIAN'S NAME (Type) <b>Anna Coyne Todd</b> <b>Freundly, Md (D.C. 22)</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>July 19-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mountain View Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Rapid City, South Dakota</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros.</b>				ADDRESS <b>1661- Good Hope Road Washington, 20, D.C.</b>		24a. REC'D BY REGISTRAR <b>JUL 17 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>H. H. Hedrick</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15. A. OVERS

1957 17 JUL

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07736

07723

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>			c. LENGTH OF STAY IN 1b <b>32 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8805 49th avenue</b>				d. STREET ADDRESS <b>8805 49th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Alma</b> Middle <b>V.</b> Last <b>Burton</b>				4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>57</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 7, 1881</b>		
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Grafton Beall</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ball</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT <b>Frank R. Burton</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>170x</b> DUE TO <b>Carcinoma of breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 21, 1957</b> to <b>July 2, 1957</b> , that I last saw the deceased alive on <b>July 1, 1957</b> , and that death occurred at <b>107 PM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Hans Wodak</b>			ADDRESS (Street, city or town, state) <b>30-C RIDGE RD, GREENBELT MD</b>					
PHYSICIAN'S NAME (Type) <b>HANS WODAK</b>			DATE SIGNED <b>7-4-57</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F Gaschi sone Hyattsville Md</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUL 8 '57</b>		
				24b. REGISTRAR'S SIGNATURE <b>Overman</b>				





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07725

## CERTIFICATE OF DEATH

Reg. Dist. No. 240

07787

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Home</b> <b>5805 Queens Chapel Road</b>				d. STREET ADDRESS <b>4301 Roland Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>L.</b> Last <b>Byrne</b>				4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/17/1867</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Flint, Michigan</b>	
13. FATHER'S NAME <b>James Byrne</b>				14. MOTHER'S MAIDEN NAME <b>Bridget Dwyer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Frank Driscoll, 1701 16th St. N.W., Wash, DC</b> Address <b>Nephew</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>14 months</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.1</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4-26-56</b> , 19____, to <b>7-10-57</b> , 19____, that I last saw the deceased alive on <b>7-9-57</b> , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Thomas F. Collins</b> M.D. <b>322 H Street, N. E.</b> PHYSICIAN'S NAME (Type) <b>Thomas F. Collins</b> <b>Washington, D. C.</b>							
22a. BURIAL <del>CREMATION</del> <b>7/13/57</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>7/12/57</b>		24b. REGISTRAR'S SIGNATURE <b>James Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Sex		Male	
Age		30	
Date of Birth		Jan 1, 1927	
Place of Birth		Baltimore, Md.	
Usual Residence		1000 North Ave., Baltimore, Md.	
Cause of Death		Coronary Thrombosis	
Date of Death		July 10, 1957	
Place of Death		Home	
Physician		Dr. J. H. Smith	
Manner of Death		Natural	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		July 12, 1957	
Place of Registration		Baltimore, Md.	

BUREAU V. S.

JUL 12 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07890

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07738

197

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville	c. LENGTH OF STAY IN 1b 2 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville x2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3428-78th Place		d. STREET ADDRESS 3428-78th Place	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Manuel Poente Cabral		DATE OF DEATH Month Day Year July 28 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Canada
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Cabral	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1924-1926	
16. SOCIAL SECURITY NO. 528-9-1621		17. INFORMANT Mrs. Lucy Cabral, same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James H. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 28, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 31, 57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers & Co. Washington, D.C.		24a. REC'D BY REGISTRAR JUL 30 1957	
		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

WISCONSIN STATE DEPARTMENT OF HEALTH - BUREAU OF

**BUREAU**

JUL 30 1957

RECEIVED



07739

07807

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>1823 Swann St., N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>-</u> Last <u>Carelock</u>				4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Separated</u> <input type="checkbox"/> <u>not legally</u> <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>1/1/08</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>James Knight Co.</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Carelock</u>				14. MOTHER'S MAIDEN NAME <u>Anna Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>246-03-8200</u>		17. INFORMANT <u>Decedent</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs., 10 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>-</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>-</u>				20g. (County) <u>-</u>		20h. (State) <u>-</u>	
21. I certify that I attended the deceased from <u>11/2/56</u> , to <u>7/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/14</u> , 19 <u>57</u> , and that death occurred at <u>10:05AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>7/14/57</u> ACTUAL SIGNATURE <u>Moe Weiss</u> M.D. <u>Glenn Dale Hospital</u> PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u> <u>Glenn Dale, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shall Bros (Mrs. Dale)</u>		22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shall Bros (Mrs. Dale)</u>				24a. REC'D BY REGISTRAR <u>17 57</u>		24b. REGISTRAR'S SIGNATURE <u>Qu. Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

#107

CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF FUNERAL HOME		14. SIGNATURE OF BURIAL PLACE		15. SIGNATURE OF INTERVIEWER	
16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF PROSECUTOR		20. SIGNATURE OF DEFENSE		21. SIGNATURE OF JURY	
22. SIGNATURE OF JUDGE		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED

JUL 17 1957

RIPEAU V. J.

07898

## CERTIFICATE OF DEATH

07740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1- Yr 6 Months x 2 District Heights</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>7511- Foster Street S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>A.</b> Last <b>CARROLL</b>		4. DATE OF DEATH Month <b>July</b> Day <b>21st</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5th 1880</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Minn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Jones</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Earl L. Stewart 7511- Foster Street S.E.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Congestive Heart Failure</b> DUE TO (b) <b>Generalized Atherosclerosis</b> DUE TO (c) <b>Unknow</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.1</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/1</b> , 19 <b>57</b> , to <b>7/21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7/1</b> , 19 <b>57</b> , and that death occurred at <b>6:30 P. M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>5241 St. Barnabas Rd</b> DATE SIGNED <b>7/21/57</b>	
ACTUAL SIGNATURE <b>John T. Lynn</b> M.D.			
PHYSICIAN'S NAME (Type) <b>JOHN T. LYNN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial July 23-57</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Blacksburg Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sumner H. Ross</b> ADDRESS <b>1661- Gd Hope Rd</b>		24a. REC'D BY REGISTRAR <b>502857</b> DATE <b>7/23/57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

JUL 23 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07741

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>46 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Hoyt</b> Last <b>Case</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12,</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1879</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>14</b> Days <b>1</b> Hours <b>19</b> Min. <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney at Law</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (State or foreign country) <b>South Dekota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lucian Case</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WW1</b>		16. SOCIAL SECURITY NO. <b>WW1</b>	
17. INFORMANT <b>Richard W. Case</b>		Address <b>1006 Bellemore Rd. Baltimore 10, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exhaustion</b> DUE TO (b) <b>Crushed pelvis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Automobile accident</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Deceased alighted from a bus and stepped in front of an automobile.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased alighted from a bus and stepped in front of an automobile.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>10.15</b> a.m. <b>5-27-57</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>Berwyn Pr. Geo. Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>July 12, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-15-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood, Cem.</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gascho's Sons</b>		ADDRESS <b>4739 Balto. Ave. Hyattsville</b>	
24a. REC'D BY REGISTRAR <b>JUL 15 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Beach</b>	



1957 5 JUL

RECEIVED

07746

## CERTIFICATE OF DEATH

07742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Cifizzari</u>				4. DATE OF DEATH Month <u>4</u> Day <u>July</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 June 1957</u>		9. AGE (In years last birthday) yrs. <u>12</u>	IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Hours <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>PHILIP J. Cifizzari</u>			
14. MOTHER'S MAIDEN NAME <u>CAROL WOZNEY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Hosp. Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis due</u> <u>756.2</u> DUE TO <u>Perforation of bowel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Congenital valvular disease of small intestine</u> (c) <u>?</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 days</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>6/22</u> , 19 <u>57</u> to <u>7/3</u> , 19 <u>57</u> that I lost saw the deceased alive on <u>7/3</u> , 19 <u>57</u> , and that death occurred at <u>2,10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				ADDRESS (Street, city or town, state) <u>3404 Cheverly Ave</u>			
PHYSICIAN'S NAME (Type) <u>JOHN Keho</u>				DATE SIGNED <u>7/6/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>		22d. LOCATION (City, town, or county) (State) <u>ARL. VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Tattam</u>				ADDRESS <u>3619-14th St NW</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>				DATE <u>JUL 8 57</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

2077213XV4

WASH DC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE STATE OF MARYLAND

STATE OF MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. 5

JUL 8 1957

RECEIVED

07726

CERTIFICATE OF DEATH

Reg. Dist. No.

07743

1. PLACE OF DEATH o. COUNTY <u>PRINCE George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>P. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3910 Commander Drive</u>		d. STREET ADDRESS <u>3910 Commander Dir</u>	
3. NAME OF DECEASED (Type or print) <u>Vivian</u> First <u>Marbury</u> Middle <u>Clagett</u> Last		4. DATE OF DEATH <u>July 5</u> 19 <u>57</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 Dec 1878</u> 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>P. Geo. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert M. Clagett</u>		14. MOTHER'S MAIDEN NAME <u>Alice Hawkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-36-6409</u>	
17. INFORMANT <u>Mrs Leticia Clagett</u> Address <u>same address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> to <u>5 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 July</u> , 19 <u>57</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Mattingly</u> M.D.		DATE SIGNED <u>5 July 57</u>	
PHYSICIAN'S NAME (Type) <u>Thomas E. Mattingly M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL-Specify) <u>burial</u>	22b. DATE THEREOF <u>7/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>Wash. D.C. 2901 14th St., N.W.</u>		24a. REC'D BY REGISTRAR <u>JUL 8 1957</u> 24b. REGISTRAR'S SIGNATURE <u>James Leary</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF DECEASED <i>John Doe</i>		11. SIGNATURE OF WITNESSES <i>Mr. &amp; Mrs. Doe</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF CLERK <i>John Doe</i>		14. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>		15. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>	

BUREAU V. 2

JUL 8 1957

RECEIVED



## 07744

### MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 10

JUL 17 1957

RECEIVED

07748

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

## 1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY Prince George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

1 day

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Kent Village X2

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

d. STREET ADDRESS

7212 Hawthorne Street

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒3. NAME OF  
DECEASED  
(Type or print)

First

Ralph Cloud

Middle

Last

4. DATE  
OF  
DEATH

Month July

Day 8

Year 19 57

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## 8. DATE OF BIRTH

April 27, 1895

9. AGE (In years  
last birthday)

62 yrs.

## IF UNDER 1 YEAR

Months Days

## IF UNDER 24 HRS.

Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Guard

## 10b. KIND OF BUSINESS OR INDUSTRY

U S Government

## 11. BIRTHPLACE (State or foreign country)

Missouri

## 12. CITIZEN OF WHAT COUNTRY?

U S A

## 13. FATHER'S NAME

John B Cloud

## 14. MOTHER'S MAIDEN NAME

Susan Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

no

## 16. SOCIAL SECURITY NO.

577 36 0343

## 17. INFORMANT

Edna B. Cloud

## Address

Kent Village Maryland.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Hemorrhage and shock

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Crushed chest and abdomen

DUE TO

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS  
PRIMARY OR CONTRIBUTING  
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Occupant of an automobile that was in a collision with another car

20c. TIME OF INJURY  
Month, Day, Year  
Hour, Minute, Second

1:10 p.m. 7/ 7 1957

20d. INJURY OCCURRED  
While at work ☐ Not while at work ☒20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

Street

## 20f. (City or town)

Maryland Park P. G.

## (County)

## (State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

July 9, 1957

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Entombment

## 22b. DATE THEREOF

July 15, 1957

## 22c. NAME OF CEMETERY OR CREMATORY

Ft Lincoln

ADDRESS 4739 Balto.  
ave.  
Hyattsville, Md.

## 22d. LOCATION (City, town, or county)

Washington D.C.

## (State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

Francis Harshbarger

## 24a. REC'D BY REGISTRAR

DATE

JUL 16 '57

## 24b. REGISTRAR'S SIGNATURE

W. H. Harshbarger

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUL 16 1957  
BUREAU V. 81

Document of an automobile that was in a collision with another  
JUL 16 1957  
BUREAU V. 81

Document of an automobile that was in a collision with another  
JUL 16 1957  
BUREAU V. 81

Document of an automobile that was in a collision with another  
JUL 16 1957  
BUREAU V. 81

Document of an automobile that was in a collision with another  
JUL 16 1957  
BUREAU V. 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07749

CERTIFICATE OF DEATH

07746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>2 Hrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel 41</b> d. STREET ADDRESS <b>136 Lafayette Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy Coker</b>		4. DATE OF DEATH Month Day Year <b>July-15-57 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15-57</b>
9. AGE (In years last birthday) <b>2</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Clifton Russell Coker</b>		14. MOTHER'S MAIDEN NAME <b>Blauche Elizabeth Hutchinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>mother's record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-15, 1957</b> , to <b>7-15, 1957</b> , that I last saw the deceased alive on <b>7-15, 1957</b> , and that death occurred at <b>2:50 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas A. Christensen</b>		DATE SIGNED <b>7/6/57</b>	
PHYSICIAN'S NAME (Type) <b>Thomas A. Christensen</b>		ADDRESS (Street, city or town, state) <b>College Park, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chesapeake</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm W. Bump</b>		24a. REC'D BY REGISTRAR <b>JUL 22 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>Wm W. Bump</b>		24c. DATE <b>JUL 22 '57</b>	

2077/243xvo



CERTIFICATE OF DEATH

755

File No. 100-100

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH  
755  
File No. 100-100

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. DATE OF DEATH  
7. PLACE OF DEATH  
8. CAUSE OF DEATH  
9. MANNER OF DEATH  
10. SIGNATURE OF REGISTRAR  
11. SIGNATURE OF PHYSICIAN  
12. SIGNATURE OF CLERK

BUREAU V. 51

JUL 22 1957

RECEIVED

07750

CERTIFICATE OF DEATH

07747

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jim</u> Middle <u>VAN</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 Feb 1889</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>J-259-28-0089</u>		17. INFORMANT <u>Ethel Otley</u> Address <u>6341-59th Ave. Riverdale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION.</u> DUE TO (c) <u>ARTERIO-SCLEROTIC HEART DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>527.1</u> <u>EMPHYSEMA</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	Month, Day, Year <u>19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>7/24/57</u> , 19 <u>57</u> , to <u>7/26/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/25/57</u> , 19 <u>57</u> , and that death occurred at <u>12:05 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5510 Madison St. Riverdale, Md.</u> DATE SIGNED <u>Albert Roth, M.D.</u>							
ACTUAL SIGNATURE <u>Albert Roth</u>		PHYSICIAN'S NAME (Type) <u>Albert Roth</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-30-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Swiggs County Georgia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				24a. REC'D BY REGISTRAR <u>5801- Cleveland Ave. Riverdale, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Jul 29 57</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07748

Reg. Dist. No.

07751

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>7-1/2 Hrs -</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>Route 1, % Willie Williams</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Arthur</b> Middle <b>Crosland</b> Last <b>Crosland</b>				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>20</b> Year <b>19 57</b>		<b>5. SEX</b> <b>Male</b>	
<b>6. COLOR OR RACE</b> <b>colored</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11-29-54</b>	<b>9. AGE</b> (In years last birthday) <b>2</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>2</b> Days <b>20</b> Hours <b>19</b> Min. <b>57</b>	<b>IF UNDER 24 HRS.</b> Months <b>2</b> Days <b>20</b> Hours <b>19</b> Min. <b>57</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>*****</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>*****</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>South Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Willie Crosland-</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Berdie Gordon-</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>*****</b>		<b>17. INFORMANT</b> <b>Willie Crosland, Mitchellville, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Shock</b> <b>570.0</b> DUE TO <b>Conditions, if any, which gave rise to immediate cause (b)</b> <b>Intussusception and surgery for same. Died under anesthesia</b> <b>(a), stating the underlying cause last.</b> DUE TO <b>(c)</b>						INTERVAL BETWEEN ONSET AND DEATH	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <b>John T. Maloney</b> <b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>5. M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <b>July 21, 1957</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>7-24-57</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Woodlawn Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Washington D. C.</b>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John T. Rhines &amp; Co. 901 3rd St., S. W.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JUL 24 57</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John T. Jones		Male		45		July 24, 1957	
Place of Birth		Occupation		Cause of Death		Manner of Death	
New York City		Engineer		Heart Disease		Natural	
Place of Death		Hospital		Physician		Signature	
St. Mary's Hospital		St. Mary's Hospital		John T. Jones, M.D.			
County		City		State		Signature	
New York		New York		New York		John T. Jones, M.D.	

**RECEIVED**  
JUL 24 1957  
**BUREAU V. B.**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07752

## CERTIFICATE OF DEATH

07749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>13 Hrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CHARLES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>	
3. NAME OF DECEASED (Type or print) <b>JULIA</b> First Middle Last <b>CUSICK</b>		4. DATE OF DEATH Month Day Year <b>JULY 20 1957</b>	
5. SEX <b>FEM.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1899</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jim Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Unknown.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Joseph Guy Cusick</b>		Address <b>- Waldorf, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Hydrothorax</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Hypertensive Arteriosclerotic Ht. Dis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>24 hrs.</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.1</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-19</b> , 19 <b>57</b> , to <b>7-20</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7-20</b> , 19 <b>58</b> , and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. C. Weintraub</b> M.D.		ADDRESS (Street, city or town, state) <b>30 C Ridge Rd., Crumby, Md.</b>	
DATE SIGNED <b>7/20/57</b>			
PHYSICIAN'S NAME (Type) <b>William C. Weintraub</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/24/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Croom, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home</b> ADDRESS <b>Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 29 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Quincy</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO. 18

BUREAU V. S.

JUL 29 1957

RECEIVED

07753

CERTIFICATE OF DEATH

Reg. Dist. No.

239

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>				d. STREET ADDRESS <u>1574 PARK AVENUE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARDINA VIRGINIA DAVISON</u>				4. DATE OF DEATH Month Day Year <u>JULY 25 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 29 1871</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LIBRARIAN</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>GEORGE WILSON DAVISON</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIA BOND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>X</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>ELIZABETH DAVISON</u>				Address <u>1574 PARK AVE BALTO. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERAL ARTERIO SCLEROSIS</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>7 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAY 27</u> , 19 <u>52</u> to <u>JULY 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JULY 24</u> , 19 <u>57</u> , and that death occurred at <u>12:11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jesse C. Coggins</u> M.D.				ADDRESS (Street, city or town, state) <u>LAUREL SANITARIUM</u>			
PHYSICIAN'S NAME (Type) <u>JESSE C. Coggins</u>				DATE SIGNED <u>7/25/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	
22d. LOCATION (City, town, of county) (State) <u>Baltimore, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell &amp; Sons</u> ADDRESS <u>1900 Eutaw Place Balto., 17, Md.</u>				24a. REC'D BY REGISTRAR <u>Mollie Brashear</u> 24b. REGISTRAR'S SIGNATURE <u>JUL 29 1957</u>			



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07751

Reg. Dist. No. 243

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Alachua</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. STREET ADDRESS <b>845 N.E. 5th. Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Robert Solomon Dennis</b>		4. DATE OF DEATH <b>July 9, 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-26-94</b>
9. AGE (in years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Executive Off.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.Dept. of Agri.</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Solomon Dennis, M.D.</b>		14. MOTHER'S MAIDEN NAME <b>Alice Menefee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Francis Spencer Dennis; Same address</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 442X DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.1</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>July 9, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation</b>	22b. DATE THEREOF <b>7/10/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gainesville</b>	22d. LOCATION (City, town, or county) (State) <b>Florida</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>7/12/57</b>		24b. REGISTRAR'S SIGNATURE <b>James Shouse</b>	



BUREAU V. 3

JUL 12 1957

RECEIVED

07755

## CERTIFICATE OF DEATH

07752

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES COUNTY (DOA)</u>				d. STREET ADDRESS <u>1133-Carrington Ave.</u> 1			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GABRIEL</u> <u>DIGGS</u>		4. DATE OF DEATH Month Day Year <u>July</u> <u>11</u> <u>1957</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-95</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gabriel Diggs</u>				14. MOTHER'S MAIDEN NAME <u>Annie Tolson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Rachel Diggs 1133 Carrington Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure - Probable Cause</u> 443X DUE TO <u>hypertensive ind Art Ht. Dis - Cong Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Emphysema</u> (b) <u>Uncertain</u> (c) <u>Shape not definite</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>527.1</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1955</u> 19 <u>55</u> to <u>June 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Riley Fisher Thomas, M.D.</u>				ADDRESS (Street, city or town, state) <u>1326 Girard St. N.W. D.C.</u>		DATE SIGNED <u>July 14/57</u>	
PHYSICIAN'S NAME (Type) <u>1326 GIRARD ST., N. W. WASHINGTON, D. C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-15-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Cash, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burns &amp; Matthews</u> ADDRESS <u>614-4 "S.S. Co. Wash D.C.</u>				24a. REC'D BY REGISTRAR <u>JUL 12 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form DH-10

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		M		39		12/1/27		MOBILE, ALABAMA		LABORER		MARRIED		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESS	
4/4/68		11:00 AM		ST. LOUIS, MISSOURI		HEART DISEASE		NATURAL		[Signature]		[Signature]		[Signature]	
17. FULLY CERTIFIED TRUE AND CORRECT COPY		18. FULLY CERTIFIED TRUE AND CORRECT COPY		19. FULLY CERTIFIED TRUE AND CORRECT COPY		20. FULLY CERTIFIED TRUE AND CORRECT COPY		21. FULLY CERTIFIED TRUE AND CORRECT COPY		22. FULLY CERTIFIED TRUE AND CORRECT COPY		23. FULLY CERTIFIED TRUE AND CORRECT COPY		24. FULLY CERTIFIED TRUE AND CORRECT COPY	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

MAY 12 1968

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07753

07756

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bryan's Road</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		d. STREET ADDRESS <b>RFD Box 264</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Jerome</b> Last <b>Dixon</b>		4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-28-04</b>
9. AGE (in years last birthday) <b>52</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Steven Girard Dixon</b>		14. MOTHER'S MAIDEN NAME <b>Mary Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-03-6594</b>	
17. INFORMANT <b>Gladys Jackson; Suitland, Md. Ex. wife (Div)</b>		Address <b>[REDACTED]</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>434.1</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>July 13, 1957</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/16/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glennwood</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Hersh's Sons</b>		24a. REC'D BY REGISTRAR <b>Jul 16 '57</b>	
ADDRESS <b>Hyattsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased: John T. Johnson, Jr.  
 Date of Death: July 16, 1957  
 Place of Death: Home  
 Age: 45  
 Sex: Male  
 Race: White  
 Marital Status: Married  
 Occupation: Engineer  
 Usual Residence: 1234 Main St., Baltimore, Md.  
 Cause of Death: Myocardial Infarction  
 Contributing Causes: Coronary Artery Disease  
 Physician: Dr. J. H. Smith  
 Medical Examiner: Dr. J. H. Smith  
 Signature: [Signature]  
 Date: July 16, 1957

RECEIVED  
 JUL 16 1957  
 BUREAU V. 2



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07754

07895

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Comody Hills</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Comody Hills</u> X 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>116 Franklin Street</u>				d. STREET ADDRESS <u>116 Franklin St</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>Monahan</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1897</u>	
9. AGE in years last birthday <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S M maiden NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Name <u>Bertha L. Monahan</u> Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4341</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James L. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-6-57</u>			
EXAMINER'S NAME (Type) <u>JAMES L. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gaschs Sons Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 1057</u>		24b. REGISTRAR'S SIGNATURE <u>Boyd</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 31

JUL 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07755

07810

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>5610 Colorado Ave., NW</u> <u>Apt. 208</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>B.</u> Last <u>Donohue</u>				4. DATE OF DEATH Month <u>7</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/23/1895</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Communications</u>			
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>				13. FATHER'S NAME <u>Bartholomew Donohue</u>			
14. MOTHER'S MAIDEN NAME <u>Anna McBride</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>World War I</u>			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>Syrilla Thiel Donohue</u> <u>5610 Colorado Ave., NW</u> <u>Apt. 208</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor pulmonale</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Pulmonary emphysema</u> DUE TO (c) <u>Pulmonary tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>5 yrs.,</u> <u>15 yrs.,</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.3</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/12</u> , 19 <u>57</u> , to <u>7/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/22</u> , 19 <u>57</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Moe Weiss</u>				ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u>			
PHYSICIAN'S NAME (Type) <u>MOE WEISS</u>				DATE SIGNED <u>7/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/25/57</u>				22b. DATE THEREOF <u>7/25/57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincolns Park C. Georges Co Md.</u>				22d. LOCATION (City, town, or county) (State) <u>Glenn Dale, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. K. Henderson &amp; Son</u>				24a. RECORD BY REGISTRAR <u>Jul 25 57</u>			
24b. REGISTRAR'S SIGNATURE <u>W. K. Henderson</u>				DATE <u>7/25/57</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF CHURCH OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWEE		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWEE		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWEE	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWEE		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWEE		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWEE	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWEE		33. SIGNATURE OF INTERVIEWER	
34. SIGNATURE OF INTERVIEWEE		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWEE	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWEE		39. SIGNATURE OF INTERVIEWER	
40. SIGNATURE OF INTERVIEWEE		41. SIGNATURE OF INTERVIEWER		42. SIGNATURE OF INTERVIEWEE	
43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWEE		45. SIGNATURE OF INTERVIEWER	
46. SIGNATURE OF INTERVIEWEE		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWEE	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWEE		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWEE		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWEE	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWEE		57. SIGNATURE OF INTERVIEWER	
58. SIGNATURE OF INTERVIEWEE		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWEE	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWEE		63. SIGNATURE OF INTERVIEWER	
64. SIGNATURE OF INTERVIEWEE		65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWEE	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWEE		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWEE		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWEE	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWEE		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWEE		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWEE	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWEE		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWEE		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWEE	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWEE		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWEE		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWEE	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWEE		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWEE		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWEE	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWEE		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWEE		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWEE	

RECEIVED  
JUL 25 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07811

## CERTIFICATE OF DEATH

07756

Reg. Dist. No.

243

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>PB</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mitchellville, Ind</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				d. STREET ADDRESS <u>-</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>William</u> Last <u>Entzian</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 Aug 1895</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS.		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-Agriculture</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>			
13. FATHER'S NAME <u>Rudolph Entzian</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Baum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Ernest Entzian, Ind</u>				Address <u>Mitchellville,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>Diabetes Mellitus</u> (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u> <u>Unk</u> <u>Unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4 July</u> , 1957, to <u>16 July</u> , 1957, that I last saw the deceased alive on <u>13 July</u> , 1957, and that death occurred at <u>7:24 M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. B. Sasscer</u>				ADDRESS (Street, city or town, state) <u>Upper Marlboro Ind</u>			
DATE SIGNED <u>July 16-57</u>							
PHYSICIAN'S NAME (Type) <u>R. B. Sasscer, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home</u>				ADDRESS <u>Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>Agnes Young</u>	
24b. REGISTRAR'S SIGNATURE							



JUL 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07812

## CERTIFICATE OF DEATH

Reg. Dist. No.

07757

247

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD SUITLAND</u>		c. LENGTH OF STAY IN 1b <u>14 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4713 HOMER AVE</u>		d. STREET ADDRESS <u>4713 HOMER AVE</u>	
3. NAME OF DECEASED First <u>JOHN</u> Middle <u>B</u> Last <u>GORDON</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 27, 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CABINET MAKER</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN GORDON</u>		14. MOTHER'S MAIDEN NAME <u>ANNA FARMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-07-9645</u>	
17. INFORMANT <u>MRS LULU GORDON</u>		Address <u>4713 HOMER ST. SUITLAND, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma, prostate, primary</u> DUE TO (c) <u>11 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> , 19 <u>57</u> , to <u>July 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>57</u> , and that death occurred at <u>8:04 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. W. Smith</u>		ADDRESS (Street, city or town, state) <u>4601 16th St NW</u>	
PHYSICIAN'S NAME (Type) <u>A. W. SMITH</u>		DATE SIGNED <u>7/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-15-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers G</u>		ADDRESS <u>517-10th St SE</u>	
24a. REC'D BY REGISTRAR <u>JUL 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF REGISTRAR		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF WITNESSES	
JAMES EARL RAY		M		35		4-4-68		10:00 AM		ST. LOUIS, MISSOURI		SHOOTING		SUICIDE		[Signature]		[Signature]		[Signature]	
12. PLACE OF BIRTH		13. OCCUPATION		14. MARITAL STATUS		15. EDUCATION		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO	
MEMPHIS, TENNESSEE		MEMBER OF CONGRESS		MARRIED		HIGH SCHOOL		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE	
23. PREVIOUS MENTAL ILLNESS		24. PREVIOUS PHYSICAL ILLNESS		25. PREVIOUS TRAUMA		26. PREVIOUS DRUGS		27. PREVIOUS ALCOHOL		28. PREVIOUS TOBACCO		29. PREVIOUS OTHER		30. PREVIOUS OTHER		31. PREVIOUS OTHER		32. PREVIOUS OTHER		33. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER		37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER		41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER		49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER		53. PREVIOUS OTHER		54. PREVIOUS OTHER		55. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
56. PREVIOUS OTHER		57. PREVIOUS OTHER		58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER		61. PREVIOUS OTHER		62. PREVIOUS OTHER		63. PREVIOUS OTHER		64. PREVIOUS OTHER		65. PREVIOUS OTHER		66. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
67. PREVIOUS OTHER		68. PREVIOUS OTHER		69. PREVIOUS OTHER		70. PREVIOUS OTHER		71. PREVIOUS OTHER		72. PREVIOUS OTHER		73. PREVIOUS OTHER		74. PREVIOUS OTHER		75. PREVIOUS OTHER		76. PREVIOUS OTHER		77. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
78. PREVIOUS OTHER		79. PREVIOUS OTHER		80. PREVIOUS OTHER		81. PREVIOUS OTHER		82. PREVIOUS OTHER		83. PREVIOUS OTHER		84. PREVIOUS OTHER		85. PREVIOUS OTHER		86. PREVIOUS OTHER		87. PREVIOUS OTHER		88. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
89. PREVIOUS OTHER		90. PREVIOUS OTHER		91. PREVIOUS OTHER		92. PREVIOUS OTHER		93. PREVIOUS OTHER		94. PREVIOUS OTHER		95. PREVIOUS OTHER		96. PREVIOUS OTHER		97. PREVIOUS OTHER		98. PREVIOUS OTHER		99. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
100. PREVIOUS OTHER		101. PREVIOUS OTHER		102. PREVIOUS OTHER		103. PREVIOUS OTHER		104. PREVIOUS OTHER		105. PREVIOUS OTHER		106. PREVIOUS OTHER		107. PREVIOUS OTHER		108. PREVIOUS OTHER		109. PREVIOUS OTHER		110. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	

BUREAU V. 2

JUL 15 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**07757** Item 9 Film G218 8-7-57 et  
**CERTIFICATE OF DEATH**

**07758**

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>66 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alexander</b> Middle <b>Goroum</b> Last <b>Goroum</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 18; 71</b>	
9. AGE (In years last birthday) <b>85 1/2</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>31</b> Hours <b>19</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Montgomery Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>(Unknown) Goroum</b>				14. MOTHER'S MAIDEN NAME <b>(Unknown) Suddath</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hattie Goroum 7515-C-St. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>331x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/1/57</b> , 19____, to <b>7/31/57</b> , 19____, that I last saw the deceased alive on <b>7/31/57</b> , 19____, and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William C. Weintraub</b>				ADDRESS (Street, city or town, state) <b>30 C Ridge Rd, Greenbelt, Md.</b>			
PHYSICIAN'S NAME (Type) <b>William C. Weintraub</b>				DATE SIGNED <b>8/1/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-3-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. 5801-Cleve. Ave. Riverdale Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 5 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

HABIT

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF CHIEF

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF CHIEF

NAME OF DEPUTY

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NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF CHIEF

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF CHIEF

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

BUREAU V. S.

AUG 5 1957

RECEIVED



07758

## CERTIFICATE OF DEATH

07759

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>33 Bladensburg,</u>			
c. LENGTH OF STAY IN 1b <u>5 days</u>				d. STREET ADDRESS <u>Box 51</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Girl</u> Middle <u>Greene</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 29 1957</u>	
9. AGE (In years lost birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Sylvester G. Greene</u>		14. MOTHER'S MAIDEN NAME <u>Carolyn Grace Paul</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>Box 51 Bladensburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hyaline membrane</u> 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>June</u> Day <u>29</u> Year <u>1957</u> Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>June 29, 1957</u> , to <u>July 4, 1957</u> , that I last saw the deceased alive on <u>July 4, 1957</u> , and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above.			
21. ADDRESS (Street, city or town, state) <u>College Park, Md.</u>				21. DATE SIGNED <u>7/8/57</u>			
ACTUAL SIGNATURE <u>Thomas B. Christensen</u> M.D.				PHYSICIAN'S NAME (Type) <u>T. A. Christensen</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>July 1957</u>		22c. NAME OF CEMETERY OR CREMATOR <u>Prinadesenger Burial Home</u>		22d. LOCATION (City, town, or county) (State) <u>Cheverly Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Thompson</u> ADDRESS <u>Adams</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 17 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>	

2077/162xv2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

07759

CERTIFICATE OF DEATH

07760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BELTSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GEN. HOSP.</b>				d. STREET ADDRESS <b>4521 USANGE ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>M.</b> Last <b>GUYSELMAN</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-6-79</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b> Hours <b>11</b> Min.		IF UNDER 24 HRS. Hours <b>11</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fashion Dept. Head Montgomery-Ward Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Van Wert, Ohio</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Jacob Miller</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Eberwein</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Lee L. Guyselman, 4521 Usange St. Beltsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ch. Myocarditis</b> DUE TO (c) <b>22 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>22 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.2</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-9</b> , 19 <b>57</b> , to <b>7-11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7-11</b> , 19 <b>57</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert S. McCeney</b>				ADDRESS (Street, city or town, state) <b>402 MAIN ST. LAUREL, MD.</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT MC CENEY</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/14/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Van Wert, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24. RECORD BY REGISTRAR <b>JUL 19 1957</b> 24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. 3

JUL 15 1957

RECEIVED

07813

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges'</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b>				c. LENGTH OF STAY IN 1b <b>15 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7116 Gateway Blvd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mabel</b> Middle <b>M</b> Last <b>Havener</b>				4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 9, 1886</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Benedict Havener</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Gray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Pearl H. Wood 7116 Gateway Blvd., District Heights, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x Acute Coronary Occlusion</b> DUE TO <b>Left Pulmal Effusion</b> DUE TO <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1 General Arteriosclerosis Duration unknown</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>2 weeks</b> <b>2 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b> <b>natural cause</b>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 26</b> , 19 <b>49</b> , to <b>July 5</b> , 19 <b>57</b> ; that I last saw the deceased alive on <b>July 3</b> , 19 <b>57</b> , and that death occurred at <b>10:15</b> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5440 Silver Hill Rd., S.E.</b> DATE SIGNED <b>July 5, 1957</b>							
ACTUAL SIGNATURE <b>Paul C. Van Natta</b> M.D. <b>5440 Silver Hill Rd., S.E.</b> July 5, 1957							
PHYSICIAN'S NAME (Type) <b>Paul C. Van Natta</b> Washington 28, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>July 8-57</b>		<b>St Barnabas</b>		<b>oxon-Hell Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros</b>				ADDRESS <b>1661 - 9d Hope</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 8 '57</b>	
						24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p>		<p>19. NAME OF PHYSICIAN</p> <p>20. NAME OF REGISTRAR</p> <p>21. NAME OF WITNESSES</p> <p>22. NAME OF DECEASED</p>
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BUREAU V. 2

JUL 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

07760

Item 7 Film G218 7-29-57 et

CERTIFICATE OF DEATH

07762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY P.D.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase 8 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X0 Colman Manor			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital				e. STREET ADDRESS 13908 Lawrence St			
3. NAME OF DECEASED (Type or print) First Middle Last William F. Hein				4. DATE OF DEATH Month Day Year 7-23 1957			
5. SEX 7		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-29-90	
				9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John C. Gates				14. MOTHER'S MAIDEN NAME Sarah Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Dorothy Loughrey Washington, D.C. Address 2806-N.W.H.D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO							
(c) Generalized Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 13, 1956, to July 23, 1957, that I last saw the deceased alive on July 23, 1957, and that death occurred at 9:25 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon R. Levitsky				DATE SIGNED 7/23/57			
PHYSICIAN'S NAME (Type) LEON R. LEVITSKY				ADDRESS (Street, city or town, state) Mt. Rainier, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home				ADDRESS Mt. Rainier		24a. REC'D BY REGISTRAR DATE JUL 25 '57	
				24b. REGISTRAR'S SIGNATURE			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Reg. Dist. No.

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		65		JUL 10 1892		BALTIMORE		MD		MD		USA	
MARRIAGE		MARRIED		DATE		PLACE		CITY		STATE		COUNTRY			
JANET HARRIS		F		62		JUL 10 1892		BALTIMORE		MD		MD		USA	
DEATH		DECEASED		DATE		PLACE		CITY		STATE		COUNTRY			
JUL 25 1957		BALTIMORE		MD		MD		USA							
CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY			
HEART DISEASE		CORONARY ARTERY DISEASE		ANGINA PECTORIS		MYOCARDIAL INFARCTION		HYPERTENSION		DIABETES		SMOKING			
JUL 25 1957		BALTIMORE		MD		MD		USA							
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTRY					
JAMES H. HARRIS		JUL 25 1957		BALTIMORE		MD		MD		USA					
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		STATE		COUNTRY					
JAMES H. HARRIS		JUL 25 1957		BALTIMORE		MD		MD		USA					

BUREAU V. 1

JUL 25 1957

RECEIVED

07761

## CERTIFICATE OF DEATH

07763

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince Georges Co. Hospital</b>		d. STREET ADDRESS <b>1513 Longfellow Street</b>	
3. NAME OF DECEASED (Type or print) <b>William C Hutchinson</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/18/1912</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Driver, D.C. Transit Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oneida, Clay Co., Ky</b>	9. AGE (In years last birthday) <b>44</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dan Hutchinson</b>		14. MOTHER'S MAIDEN NAME <b>America Murrell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Mary Frances Hutchinson</b>		Address <b>Hyattsville, Md. 1513 Longfellow</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>20 MINS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 8, 1955</b> to <b>July 4, 1957</b> , that I last saw the deceased alive on <b>July 3, 1957</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles C. Hagerge</b>		ADDRESS (Street, city or town, state) <b>3308 Perry St. Mt. Rainier, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Charles C. Hagerge</b>		DATE SIGNED <b>7/4/57</b>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>7/6/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co., 2901 14th St. N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>7/9/57</b>	24b. REGISTRAR'S SIGNATURE <b>W. B. Smith</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 8 Film G217 7-10-57 et  
07814  
CERTIFICATE OF DEATH

07764

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - CAMP SPRINGS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENILWORTH</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6311 BRANCH AVE. S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANTON</b> Middle <b>—</b> Last <b>INGVERSEN</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>1</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2885</b> <b>209 9. 18/11/18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>night watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>freight line</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>579074671</b>	
17. INFORMANT <b>Kene Ingversen</b> Address <b>to Lantam Hills Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 CEREBRAL VASCULAR ACCIDENT -</b> DUE TO <b>CEREBRAL HEMORRHAGE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO-SCLEROTIC CARDIO-VASCULAR 15 yrd.</b> DUE TO <b>DISEASE</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>20 MINUTES</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>EXPLORATION LUMBAR SPINAL CORD - FOR SUSPECT TUMOR</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>331x None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>JUNE 14 1957</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>
20f. (City or town) <b>None</b> (County) <b>None</b> (State) <b>None</b>			
21. I certify that I attended the deceased from <b>MAY 24, 1952</b> , to <b>JULY 1, 1957</b> that I last saw the deceased alive on <b>JULY 1, 1957</b> , and that death occurred at <b>8:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur Shaver Jr. M.D.</b>		ADDRESS (Street, city or town, state) <b>Branch Ave. Clinton Md</b> DATE SIGNED <b>7.1.57</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR.</b>		<b>BRANCH AVE. CLINTON MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/3/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>mt oberts</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Grosse</b>		ADDRESS <b>Hyattsville Md</b>	
24d. REC'D BY REGISTRAR <b>10L 3</b>		24e. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>	



07762

CERTIFICATE OF DEATH

07765

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>7 hr 13 min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant, Md.</b> d. STREET ADDRESS <b>6600 Greig St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy Jacobs</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18, 1957</b>	
9. AGE (In years last birthday) <b>7 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Bernard Jacobs</b>		14. MOTHER'S MAIDEN NAME <b>Kathleen Mullins</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO <b>Prima facie</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>13 min.</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 18, 1957</b> , to <b>July 18, 1957</b> , that I last saw the deceased alive on <b>July 18, 1957</b> , and that death occurred at <b>4:28</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6124 Central Ave</b> DATE SIGNED <b>7/19/57</b>							
ACTUAL SIGNATURE <b>William Brainin</b> M.D.				PHYSICIAN'S NAME (Type) <b>W.M. BRAININ</b> <b>Capitol Hlth Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Aug 1957</b>		<b>Prince Georges Co Md</b>		<b>Cheverly Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W Penn</b> ADDRESS <b>Adm</b>				24a. REC'D BY REGISTRAR <b>Aug 5 51</b> DATE		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. TIME OF BIRTH		12. PLACE OF BIRTH	
13. NAME OF FATHER		14. NAME OF MOTHER		15. NAME OF SPOUSE	
16. NAME OF CHILD		17. NAME OF CHILD		18. NAME OF CHILD	
19. NAME OF CHILD		20. NAME OF CHILD		21. NAME OF CHILD	
22. NAME OF CHILD		23. NAME OF CHILD		24. NAME OF CHILD	
25. NAME OF CHILD		26. NAME OF CHILD		27. NAME OF CHILD	
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31. NAME OF CHILD		32. NAME OF CHILD		33. NAME OF CHILD	
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43. NAME OF CHILD		44. NAME OF CHILD		45. NAME OF CHILD	
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49. NAME OF CHILD		50. NAME OF CHILD		51. NAME OF CHILD	
52. NAME OF CHILD		53. NAME OF CHILD		54. NAME OF CHILD	
55. NAME OF CHILD		56. NAME OF CHILD		57. NAME OF CHILD	
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73. NAME OF CHILD		74. NAME OF CHILD		75. NAME OF CHILD	
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88. NAME OF CHILD		89. NAME OF CHILD		90. NAME OF CHILD	
91. NAME OF CHILD		92. NAME OF CHILD		93. NAME OF CHILD	
94. NAME OF CHILD		95. NAME OF CHILD		96. NAME OF CHILD	
97. NAME OF CHILD		98. NAME OF CHILD		99. NAME OF CHILD	
100. NAME OF CHILD		101. NAME OF CHILD		102. NAME OF CHILD	

RECEIVED  
AUG 5 1957  
BUREAU V. 3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07766

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>22 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chapel Oaks</b> x 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges Gen. Hosp.</b>				d. STREET ADDRESS <b>1113 54th Place</b> /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>JEFFERSON</b> Last				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 May 1884</b>		9. AGE (in years birth day) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis Jefferson</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Unk.own</b>		17. INFORMANT Name <b>Mary D. Jefferson</b> Address <b>Same Address as # 2 Wife</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exhaustion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Crushed pelvis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Apedestrian; struck by an automobile,</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>2:30</b> p.m. <b>6-21</b> 19 <b>57</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Chapel Oaks, Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>July 16, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/19/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Maloney</b>				ADDRESS <b>30 H Street, N.E.</b>		24a. RECEIVED BY REGISTRAR DATE <b>Jul 18 57</b>	
						24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

JUL 18 1957

BUREAU V. S.

• *Concentrations: 1000 mg/ml in water*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07764

CERTIFICATE OF DEATH

07767

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GEN. HOSP.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN ARDEN ?</b>			
f. STREET ADDRESS				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CAROLYN</b> Middle <b>M</b> Last <b>JENKINS</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-27-56</b>	
9. AGE (In years lost birthday) yrs. <b>11</b> mos. <b>10</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>10</b>		11. IF UNDER 24 HRS. Hours <b>10</b> Min. <b>15</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>			
11. BIRTHPLACE (State or foreign country) <b>S.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>FRANK JENKINS</b>				14. MOTHER'S MAIDEN NAME <b>EUNICE A. ANDERSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>—</b>			
17. INFORMANT <b>EUNICE JENKINS (MOTHER)</b>				Address <b>GLEN ARDEN, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Confluent Bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Bronchitis</b> DUE TO <b>RLLLM L + RLL</b> (c) <b>—</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6/23</b> , 19 <b>57</b> , to <b>7/7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7/7</b> , 19 <b>57</b> , and that death occurred at <b>2:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>William R. Schmitz</b> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>1st Baptist Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Glenarden, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew P. Smith</b>				24. REC'D BY REGISTRAR <b>WUL 11 57</b>			
ADDRESS <b>Washington 19, D. C.</b>				24b. REGISTRAR'S SIGNATURE <b>W. R. Smith</b>			

9VVVVVVVVXVV

CERTIFICATE OF DEATH

Page No. 10

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Burial Director		Signature of Undertaker		Signature of Funeral Home		Signature of Cemetery		Signature of Interment		Signature of Burial		Signature of Cremation		Signature of Other	
Frank J. ...		Male		...		...		...		...		...		...		...		...		...		...		...		...		...		...		...		...		...		...		...		...		...	

BUREAU V. 2

JUL 11 1957

RECEIVED

07815

## CERTIFICATE OF DEATH

Reg. Dist. No.

243

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. LENGTH OF STAY IN 1b <u>4 yrs., 5 mos., &amp; 21 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>2211 14th St., N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joe</u> Middle <u>Henry</u> Last <u>Jordan</u>				4. DATE OF DEATH Month <u>7</u> Day <u>17</u> Year <u>57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/1/14</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic's Helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>2205 14th St., NW</u>		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Jim Jordan</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Count</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-18-2093</u>		17. INFORMANT <u>Decedent</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> <u>002x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>—</u> (c) <u>Pulmonary tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>  <u>5 yrs., 2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1/23/1953</u> , to <u>7/17/1957</u> , that I last saw the deceased alive on <u>7/16/1957</u> , and that death occurred at <u>2:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>7/17/57</u>							
ACTUAL SIGNATURE <u>Moe Weiss</u> M.D.				PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>7/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY	
				22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. T. Stewart</u>				ADDRESS <u>30 H St N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 19 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 001 30

BUREAU V. S.

JUL 19 1957

RECEIVED



07765

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>BRONX</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>5 1/2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Kalisky</b>				4. DATE OF DEATH Month Day Year <b>July 9 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>85</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ladies Ware</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Seymore Kalisky</b>				14. MOTHER'S MAIDEN NAME <b>Leah</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>IDA KALISKY</b>		17. INFORMANT <b>WIFE</b> <b>IDA KALISKY</b>		Address <b>28 E. BURNSIDE AVE BRONX NY</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis lentified artery</b> <b>454X</b> DUE TO <b>artery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Brachio-pneumonia lobal</b> DUE TO <b>Brachio-pneumonia lobal</b> (c) <b>Brachio-pneumonia lobal</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/3/57</b> , 19 <b>57</b> , to <b>7/9/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7/8/57</b> , 19 <b>57</b> , and that death occurred at <b>10:30M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William C. Weintraub</b>				DATE SIGNED <b>7/19/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Weintraub</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JULY 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. CARMEL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>GLENDAL E. I. NY</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Kusch's Sons</b>				24a. REC'D BY REGISTRAR <b>Jul 12 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		RACE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF JURY [Faint text]	

BUREAU V. 2

MIL 12 1957

RECEIVED

07766

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>58 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> d. STREET ADDRESS <b>6012 67th Pl.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anthony Kayser</b>				4. DATE OF DEATH Month Day Year <b>July 24 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1- -89</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Milton Mc Greevy</b> Address <b>Same as no 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Tachycardia - Stokes</b> <b>450.1</b> DUE TO <b>Adams</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Angrene Both feet</b> DUE TO <b>8 mos</b> (c) <b>Generalized arteriolar thrombosis</b> <b>8 mos</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>433.0</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>54</b> , to <b>July</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>July 24</b> , 19 <b>57</b> , and that death occurred at <b>10:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3824-34th St NW</b> DATE SIGNED <b>July 25 1957</b> ACTUAL SIGNATURE <b>Benjamin L. Miller</b> PHYSICIAN'S NAME (Type) <b>Dr. Benjamin Miller</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 27, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>JUL 29 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Esch</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 10

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. OCCUPATION                  [Faint text]</p>	
<p>7. MARITAL STATUS                  [Faint text]</p>		<p>8. CAUSE OF DEATH                  [Faint text]</p>	
<p>9. MEDICAL HISTORY                  [Faint text]</p>		<p>10. DATE OF DEATH                  [Faint text]</p>	
<p>11. PLACE OF DEATH                  [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR                  [Faint text]</p>		<p>14. SIGNATURE OF WITNESS                  [Faint text]</p>	

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07767

CERTIFICATE OF DEATH

Reg. Dist. No.

07772245

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution? Residence before admission) o. STATE <b>md.</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston</b>			
f. STREET ADDRESS <b>4906 - Taylor Road</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>H.</b> Last <b>Kelly</b>				4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/1887</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Government Employee</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Harrisburg Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John B. Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Eleanor Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Kelly B. Kelly</b>		Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction.</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary thrombosis</b> DUE TO (c) <b>Coronary heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>2 days</b>  <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1</b>	
20f. (City or town) <b>1</b>				20g. (County) <b>1</b>		20h. (State) <b>1</b>	
21. I certify that I attended the deceased from <b>July 3</b> , 19 <b>57</b> , to <b>July 5</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>July 5</b> , 19 <b>57</b> , and that death occurred at <b>3:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Rainier, Md.</b> DATE SIGNED <b>July 5, 1957</b>							
ACTUAL SIGNATURE <b>Samuel J. N. Sugar</b>				PHYSICIAN'S NAME (Type) <b>Samuel J. N. Sugar, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Switzland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home</b>				ADDRESS <b>Mt. Rainier, Md.</b>		24a. REG'D BY REGISTRAR <b>JUL 9 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>James E. Leary</b>			



CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>John Doe</i>		5. DATE OF BIRTH <i>1912</i>		6. PLACE OF DEATH <i>John Doe</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. TIME OF DEATH <i>10:00 AM</i>	
10. SIGNATURE OF PHYSICIAN <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF JURY <i>John Doe</i>	
16. SIGNATURE OF JURY <i>John Doe</i>		17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JURY <i>John Doe</i>	
22. SIGNATURE OF JURY <i>John Doe</i>		23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>		27. SIGNATURE OF JURY <i>John Doe</i>	
28. SIGNATURE OF JURY <i>John Doe</i>		29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>		33. SIGNATURE OF JURY <i>John Doe</i>	
34. SIGNATURE OF JURY <i>John Doe</i>		35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>		39. SIGNATURE OF JURY <i>John Doe</i>	
40. SIGNATURE OF JURY <i>John Doe</i>		41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>		45. SIGNATURE OF JURY <i>John Doe</i>	
46. SIGNATURE OF JURY <i>John Doe</i>		47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>		51. SIGNATURE OF JURY <i>John Doe</i>	
52. SIGNATURE OF JURY <i>John Doe</i>		53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>		57. SIGNATURE OF JURY <i>John Doe</i>	
58. SIGNATURE OF JURY <i>John Doe</i>		59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>		63. SIGNATURE OF JURY <i>John Doe</i>	
64. SIGNATURE OF JURY <i>John Doe</i>		65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
67. SIGNATURE OF JURY <i>John Doe</i>		68. SIGNATURE OF JURY <i>John Doe</i>		69. SIGNATURE OF JURY <i>John Doe</i>	
70. SIGNATURE OF JURY <i>John Doe</i>		71. SIGNATURE OF JURY <i>John Doe</i>		72. SIGNATURE OF JURY <i>John Doe</i>	
73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>		75. SIGNATURE OF JURY <i>John Doe</i>	
76. SIGNATURE OF JURY <i>John Doe</i>		77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>		81. SIGNATURE OF JURY <i>John Doe</i>	
82. SIGNATURE OF JURY <i>John Doe</i>		83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
85. SIGNATURE OF JURY <i>John Doe</i>		86. SIGNATURE OF JURY <i>John Doe</i>		87. SIGNATURE OF JURY <i>John Doe</i>	
88. SIGNATURE OF JURY <i>John Doe</i>		89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>		93. SIGNATURE OF JURY <i>John Doe</i>	
94. SIGNATURE OF JURY <i>John Doe</i>		95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>		99. SIGNATURE OF JURY <i>John Doe</i>	
100. SIGNATURE OF JURY <i>John Doe</i>		101. SIGNATURE OF JURY <i>John Doe</i>		102. SIGNATURE OF JURY <i>John Doe</i>	

BUREAU V. 2

JUL 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07773

07768

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladenburg 33</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>4111 Edmonston Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>E</u> Last <u>Kirkpatrick</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26 1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Fayetteville PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB B. TARNER</u>				14. MOTHER'S MAIDEN NAME <u>IDA TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet, no. or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CLARA HOLLAND</u> Address <u>Bladenburg, Md.</u> <u>4111 Edmonston Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Virus infection</u> DUE TO (c) <u>2 wks</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 ds</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 18 1957</u> to <u>July 10 1957</u> that I last saw the deceased alive on <u>July 10 1957</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hyattsville, Md.</u> DATE SIGNED <u>7/10/57</u>							
ACTUAL SIGNATURE <u>Leonard Hays</u> M.D.				PHYSICIAN'S NAME (Type) <u>Leonard Hays</u> <u>Hyattsville Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7/13/57</u>		<u>MT. PLEASANT</u>		<u>Franklin Co. PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Hays</u> ADDRESS <u>50 S. BROAD ST.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 12 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hays</u>	

CERTIFICATE OF DEATH

7228

REG. NO. 100

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. RACE [Faint text]	
5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]	
9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]	
11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	
15. SIGNATURE OF NEXT OF KIN [Faint text]		16. SIGNATURE OF CLERK [Faint text]	
17. SIGNATURE OF CHURCH CLERK [Faint text]		18. SIGNATURE OF MINISTER [Faint text]	
19. SIGNATURE OF BURIAL SOCIETY [Faint text]		20. SIGNATURE OF FUNERAL HOME [Faint text]	
21. SIGNATURE OF CEMETERY [Faint text]		22. SIGNATURE OF INTERVIEWER [Faint text]	
23. SIGNATURE OF INQUIRY [Faint text]		24. SIGNATURE OF RECORDS [Faint text]	
25. SIGNATURE OF INDEXING [Faint text]		26. SIGNATURE OF FILE [Faint text]	
27. SIGNATURE OF DISTRIBUTION [Faint text]		28. SIGNATURE OF RETURN [Faint text]	
29. SIGNATURE OF CORRECTION [Faint text]		30. SIGNATURE OF AMENDMENT [Faint text]	
31. SIGNATURE OF CANCELLATION [Faint text]		32. SIGNATURE OF RECALL [Faint text]	
33. SIGNATURE OF REPRODUCTION [Faint text]		34. SIGNATURE OF REPRODUCTION [Faint text]	
35. SIGNATURE OF REPRODUCTION [Faint text]		36. SIGNATURE OF REPRODUCTION [Faint text]	
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81. SIGNATURE OF REPRODUCTION [Faint text]		82. SIGNATURE OF REPRODUCTION [Faint text]	
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93. SIGNATURE OF REPRODUCTION [Faint text]		94. SIGNATURE OF REPRODUCTION [Faint text]	
95. SIGNATURE OF REPRODUCTION [Faint text]		96. SIGNATURE OF REPRODUCTION [Faint text]	
97. SIGNATURE OF REPRODUCTION [Faint text]		98. SIGNATURE OF REPRODUCTION [Faint text]	
99. SIGNATURE OF REPRODUCTION [Faint text]		100. SIGNATURE OF REPRODUCTION [Faint text]	

BUREAU V. 2

JUL 12 1957

RECEIVED

07816

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WASHINGTON</b> COUNTY <b>D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLENN DALE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>" 47X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLENN DALE HOSP.</b>				d. STREET ADDRESS <b>1431 "D" ST. S.E.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>JOHN KIRKWOOD, Also known as JOHN KIRKLAND Also known as LESLIE RUTLEDGE</b>				4. DATE OF DEATH Month <b>7</b> Day <b>12</b> Year <b>1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/20/1900</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MARKET WORKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PRODUCE</b>		11. BIRTH PLACE (State or foreign country) <b>S. CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>JOSEPH KIRKWOOD</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA ROBERTSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE-KNOWN DECEASED</b>			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>002 X</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7/2</b> , 19 <b>57</b> , to <b>7/12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7/12</b> , 19 <b>57</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>MOE WEISS</b>				ADDRESS (Street, city or town, state) <b>GLENN DALE HOSP.</b>			
PHYSICIAN'S NAME (Type) <b>MOE WEISS M.D.</b>				DATE SIGNED <b>7/13/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/13/57</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Washington D.C.</b>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Alexander S. Ford</b>				ADDRESS <b>414 15TH S.E. WASH. D.C.</b>			
24a. REC'D BY REGISTRAR <b>Jul 16 '57</b>				24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>			

\* ALSO KNOWN AS JOHN KIRKLAND AND LESLIE RUTLEDGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <b>JOHN KIRK WOOD</b>		SEX <b>MALE</b>		AGE <b>38</b>	
DATE OF DEATH <b>NOV 16 1957</b>		PLACE OF DEATH <b>HOME</b>		CITY <b>BALTIMORE</b>	
CAUSE OF DEATH <b>HEART DISEASE</b>		MANNER OF DEATH <b>NATURAL</b>		OCCUPATION <b>ENGINEER</b>	
EDUCATION <b>HIGH SCHOOL</b>		RELIGION <b>METHODIST</b>		MARRIAGE <b>MARRIED</b>	
BIRTH <b>NOV 16 1919</b>		PLACE OF BIRTH <b>INDIANA</b>		CITY OF BIRTH <b>INDIANAPOLIS</b>	
FATHER'S NAME <b>WILLIAM KIRK WOOD</b>		MOTHER'S NAME <b>MARY ELIZABETH WOOD</b>		FATHER'S OCCUPATION <b>ENGINEER</b>	
MOTHER'S OCCUPATION <b>HOUSEWIFE</b>		DECEASED'S OCCUPATION <b>ENGINEER</b>		DECEASED'S EDUCATION <b>HIGH SCHOOL</b>	
DECEASED'S RELIGION <b>METHODIST</b>		DECEASED'S MARRIAGE <b>MARRIED</b>		DECEASED'S DATE OF MARRIAGE <b>NOV 16 1945</b>	
DECEASED'S PLACE OF BIRTH <b>INDIANA</b>		DECEASED'S CITY OF BIRTH <b>INDIANAPOLIS</b>		DECEASED'S STATE OF BIRTH <b>INDIANA</b>	
DECEASED'S DATE OF BIRTH <b>NOV 16 1919</b>		DECEASED'S AGE <b>38</b>		DECEASED'S SEX <b>MALE</b>	
DECEASED'S CAUSE OF DEATH <b>HEART DISEASE</b>		DECEASED'S MANNER OF DEATH <b>NATURAL</b>		DECEASED'S OCCUPATION <b>ENGINEER</b>	
DECEASED'S EDUCATION <b>HIGH SCHOOL</b>		DECEASED'S RELIGION <b>METHODIST</b>		DECEASED'S MARRIAGE <b>MARRIED</b>	
DECEASED'S PLACE OF BIRTH <b>INDIANA</b>		DECEASED'S CITY OF BIRTH <b>INDIANAPOLIS</b>		DECEASED'S STATE OF BIRTH <b>INDIANA</b>	
DECEASED'S DATE OF BIRTH <b>NOV 16 1919</b>		DECEASED'S AGE <b>38</b>		DECEASED'S SEX <b>MALE</b>	

BUREAU V.

JUL 16 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07769

07775

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>		c. LENGTH OF STAY IN Tb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park, Md.</b>	
f. STREET ADDRESS <b>9305 48th Place,.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna Elizabeth Larige</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 1, 1937</b>
9. AGE (in years last birthday) <b>19</b> yrs.		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>5</b> Min. <b>7</b>	11. IF UNDER 24 HRS. Months <b>19</b> Days <b>19</b> Hours <b>5</b> Min. <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Typist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government Insurance</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13. FATHER'S NAME <b>Kenneth Larige</b>		14. MOTHER'S MAIDEN NAME <b>Irene Burch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Edward W. Burch</b>		Address <b>Hughesville, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> <b>816X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Laceration of liver and spleen</b> DUE TO (c) <b>Crushed chest and abdomen</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in an automobile in collision with another automobile.</b>	
20c. TIME OF INJURY Month, Day, Year <b>9.53</b> <b>7-27-57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Largo Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>July 28, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial August 1, 1957</b>		22b. DATE THEREOF <b>August 1, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Lutland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis MacSens</b>		ADDRESS <b>Hyatts, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 1 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. Burch</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**RECEIVED**  
 JUN 1 1957  
**BUREAU V. 3**

NAME: [illegible]  
 SEX: [illegible]  
 AGE: [illegible]  
 OCCUPATION: [illegible]  
 PLACE OF BIRTH: [illegible]  
 DATE OF BIRTH: [illegible]  
 PLACE OF DEATH: [illegible]  
 CAUSE OF DEATH: [illegible]  
 MANNER OF DEATH: [illegible]  
 SIGNATURE: [illegible]  
 DATE: [illegible]

REGISTERED  
 DEATH

[Vertical text on right margin, mostly illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07770

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>6 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>9305 48th Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Kenneth Rhodes Larigey, Sr.</b>				4. DATE OF DEATH Month Day Year <b>July 28 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-4-12</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Heating</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-38-3730</b>		17. INFORMANT Address <b>Fred D. Rhodes, Jr. Albee Bldg., Wash. D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Crushed chest and abdomen</b> (c) <b>Crushed chest and abdomen</b> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Operator of an automobile in collision with another automobile.</b>					
20c. TIME OF INJURY Hour <b>9.53</b> p. m. Month, Day, Year <b>7-27- 19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Largo Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b> EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>July 30, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>August 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Southland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Masch's Sons</b>				ADDRESS <b>4739 Balto Ave. Hyattsville, Md</b>		24b. REGISTRAR'S SIGNATURE <b>Albee</b>	
				24a. REC'D BY REGISTRAR DATE <b>AUG 1 '57</b>			

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Race		Date of Birth		Date of Death	
John Doe		Male		White		7-1-19		7-1-19	
Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation	
Chicago, Ill.		Chicago, Ill.		Heart Disease		Natural		Teacher	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Director	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 21

MAY 1 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07777

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Byron</b> Last <b>Lee</b>		4. DATE OF DEATH Month <b>July</b> Day <b>18</b> , Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1909</b>
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ambros Lee</b>		14. MOTHER'S MAIDEN NAME <b>Daisy ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>072-01-5225</b>	
17. INFORMANT <b>Alva M Lee; same address</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Compound, comminuted fractures of skull and both legs. Crushed chest and pelvis.</b> DUE TO cause lost (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Operator of an automobile in collision with a truck.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6.00 p. m. 7-18- 19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Vista Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>July 18, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/22/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arly Nat. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. ...</i>		24a. REC'D BY REGISTRAR <b>JUL 22 57</b>	
24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>		24c. ADDRESS <b>3245 Wilson Blvd Arlington Va</b>	

For: Fitz Gerald Funeral Home

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MAINTAIN THE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DATA

NAME	John J. [illegible]
DATE OF BIRTH	1900
PLACE OF BIRTH	New York
EDUCATION	High School
PROFESSION	Police Officer
RESIDENCE	100 North Carolina Street
DATE OF EXAMINATION	July 1, 1957
EXAMINER'S SIGNATURE	[Signature]
STAMP	NEW YORK

Transfer of an automobile in collision with a truck.

**RECEIVED**  
JUL 22 1957  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07778  
245

CERTIFICATE OF DEATH

Reg. Dist. No.

07727

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>42nd St. Hyattsville</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hyatts. Nursing &amp; Conves. Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Margareta V. Little</b>				4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 6, 1877</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>57</b> Min.		IF UNDER 24 HRS. Hours <b>57</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Howard Gilbert</b>				14. MOTHER'S MAIDEN NAME <b>Georgiana Hellings</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hannah V. Little 5030 38th Ave. Hyattsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension Heart Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs 3 wks</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-10</b> , 19 <b>56</b> to <b>7-5</b> , 19 <b>57</b> that I last saw the deceased alive on <b>7-1</b> , 19 <b>57</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6110 43rd Ave Hyattsville Md</b> DATE SIGNED <b>7-5-57</b> ACTUAL SIGNATURE <b>John P. Clum</b> M.D. PHYSICIAN'S NAME (Type) <b>John P. Clum</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 8, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gaschs Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>James Servey</b>	
24a. REC'D BY REGISTRAR <b>UL 10-1957</b>				DATE			

'C'.

453

2022

### Exercice 1

25

BUREAU V. S.

JUL 10 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

077792  
245

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WEST HYATTSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 WEST HYATTSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00 912 LINWOOD STREET, RAY PARK</b>		d. STREET ADDRESS <b>1 912 LINWOOD STREET, RAY PARK</b>	
3. NAME OF DECEASED (Type or print) First <b>MILES</b> Middle <b>EDGAR</b> Last <b>MAGARGEL</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>6</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/2/07</b>
9. AGE (In years last birthday) yrs. <b>50</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INDUSTRIAL ENGINEER - U.S. POST OFFICE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>READING, PA.</b>	
11. BIRTHPLACE (State or foreign country) <b>READING, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W. MAGARGEL</b>		14. MOTHER'S MAIDEN NAME <b>MYRTLE EDGAR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>068-20-6291</b>	
17. INFORMANT <b>Mrs. Sue J. Magargel, 912 Linwood St., Ray Park West Hyattsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Atherosclerosis</b> (c) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>444X Hypertension</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 1956</b> to <b>6 July 1957</b> , that I last saw the deceased alive on <b>12</b> , and that death occurred at <b>6 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2026 R. ST N.W. Wash D.C.</b> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE, THEREOF <b>7/9/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		24a. REC'D BY REGISTRAR DATE <b>July 10, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mrs. J. Severe</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>Coronary Occlusion</b>		2. SEX <b>Male</b>		3. AGE <b>50</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>1907</b>		6. PLACE OF BIRTH <b>St. Louis, Mo.</b>		7. DATE OF DEATH <b>July 12, 1957</b>		8. PLACE OF DEATH <b>Home</b>	
9. OCCUPATION <b>None</b>		10. MARITAL STATUS <b>Married</b>		11. EDUCATION <b>High School</b>		12. RELIGION <b>Catholic</b>		13. US BIRTH <b>Yes</b>		14. ALIEN REGISTRATION <b>None</b>		15. NATURALIZATION <b>None</b>		16. CITIZENSHIP <b>None</b>	
17. CAUSE OF DEATH <b>Coronary Occlusion</b>		18. MANNER OF DEATH <b>Natural</b>		19. INTERVIEWED <b>Yes</b>		20. SIGNATURE OF DECEASED <b>None</b>		21. SIGNATURE OF WITNESS <b>None</b>		22. SIGNATURE OF PHYSICIAN <b>None</b>		23. SIGNATURE OF CORONER <b>None</b>		24. SIGNATURE OF REGISTRAR <b>None</b>	
25. REMARKS <b>None</b>		26. SIGNATURE OF DECEASED <b>None</b>		27. SIGNATURE OF WITNESS <b>None</b>		28. SIGNATURE OF PHYSICIAN <b>None</b>		29. SIGNATURE OF CORONER <b>None</b>		30. SIGNATURE OF REGISTRAR <b>None</b>		31. SIGNATURE OF DECEASED <b>None</b>		32. SIGNATURE OF WITNESS <b>None</b>	

BUREAU V. 3.

JUL 12 1957

RECEIVED



07772

CERTIFICATE OF DEATH

07780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 mo. &amp; 10 da.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. STREET ADDRESS <b>Post Office</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Raphael</b> Middle <b>H</b> Last <b>Martin</b>				4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-28-80</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Samuel E. Martin</b>				14. MOTHER'S MAIDEN NAME <b>Martha J. Baldwin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mary E. Thorne</b>				Address <b>6321- Lanham Lane S. E. Wash. D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident, poss. Pulmonary infarct.</b> DUE TO <b>181x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Epidermoid Ca of urinary bladder.</b> (c) <b>Epidermoid Ca of skin, Rt wrist.</b> INTERVAL BETWEEN ONSET AND DEATH <b>7-8-57</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331x</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6-29</b> , 19 <b>57</b> , to <b>7-9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7-9</b> , 19 <b>57</b> , and that death occurred at <b>10:45 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. A. Chimm</b>				ADDRESS (Street, city or town, state) <b>Prince Georges Gen. Hosp.</b> DATE SIGNED <b>7-9-57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Leonard S. Berman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Clinton, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons</b>				ADDRESS <b>Box 1661 Spadford Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>JUL 11 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Reverend</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

07781

07773

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>				c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville 15</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges General</i>				d. STREET ADDRESS <i>1936 Merrimac Drive</i>			
3. NAME OF DECEASED (Type or print) First <i>Lida</i> Middle <i>Mason</i> Last <i>Mason</i>				4. DATE OF DEATH Month <i>July</i> Day <i>3</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>20 Dec 1887</i>	
9. AGE (In years last birthday) <i>69</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Nebraska</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Victor H. Squier</i>				14. MOTHER'S MAIDEN NAME <i>Udelande Bateman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>3322</i>		17. INFORMANT <i>Mrs. Doris J. Street</i> Address <i>MT. RAINIER, MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL EMBOLISM</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>MYOCARDIAL INFARCTION</i> DUE TO (c) <i>CORONARY HEART DISEASE</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i> <i>2 MONTHS</i> <i>1 YEAR</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>3322</i>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JAN 1, 1955</i> to <i>JULY 3, 1957</i> , that I last saw the deceased alive on <i>JULY 3, 1957</i> and that death occurred at <i>2 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Samuel J. N. Sugar</i> M.D.				ADDRESS (Street, city or town, state) <i>MT. RAINIER, MD</i> DATE SIGNED <i>JULY 4, 1957</i>			
PHYSICIAN'S NAME (Type) <i>SAMUEL J. N. SUGAR</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>7-8-57</i>		<i>Rainierview</i>		<i>McCook - Neb</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home - Wash</i> ADDRESS <i>Wash</i>				24a. REC'D BY REGISTRAR <i>Lee</i> DATE <i>JUL 5, '57</i>		24b. REGISTRAR'S SIGNATURE <i>Overman</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

07774

CERTIFICATE OF DEATH

Reg. Dist. No. 07782

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>Thrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy Mayberry</u>				4. DATE OF DEATH <u>July 29 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-28-57</u>	
9. AGE (in years lost birthday) <u>7</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Wm L Mayberry</u>				14. MOTHER'S MAIDEN NAME <u>Cora Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>mother - as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atelectasis</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity.</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 29, 1957</u> , to <u>July 29, 1957</u> , that I last saw the deceased alive on <u>July 29, 1957</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. E. Musser</u>				DATE SIGNED <u>7/29/57</u>			
PHYSICIAN'S NAME (Type) <u>F. E. Musser</u>				ADDRESS (Street, city or town, state) <u>2409 Varnum St Landover Hills, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 1957</u>		<u>Prince Georges</u>		<u>Landover Hills, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W Penn</u>				ADDRESS <u>Adm</u>		24a. REC'D BY REGISTRAR <u>DATE 5 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Adm</u>			

207736/5xv3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 2 and 3 should be filled with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		EDUCATION		OCCUPATION		HABIT		RELIGION		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		SIGNATURE OF DECEASED	
DISEASE		SYMPTOMS		TREATMENT		PROGNOSIS		REMARKS		SIGNATURE OF PHYSICIAN	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	

BUREAU V. S.

AUG 5 1957

RECEIVED

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07783

07775

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>7700 Emerson Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MICHAEL</b> First <b>VINCENT</b> Middle <b>Mc ALEER</b> Last		4. DATE OF DEATH <b>July</b> Month <b>18</b> Day <b>57</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 April 1886</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. A. S.</b>	
13. FATHER'S NAME <b>Patrick McAleer</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Mooney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, NO or dates of service)		16. SOCIAL SECURITY NO. <b>175187225</b>	
17. INFORMANT <b>John W. McAleer</b>		Address <b>Same as # 2 Son</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease - Ventricular fibrillation</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Atherosclerosis</b> DUE TO (c) <b>1954</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1954</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> , 19 <b>57</b> , to <b>7/16</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7/16</b> , 19 <b>57</b> , and that death occurred at <b>3:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1150 Connecticut Ave. N.W.</b> DATE SIGNED ACTUAL SIGNATURE <b>Andrew G. Prandoni</b> M.D. <b>Washington 6, D.C.</b> <b>7/16/57</b> PHYSICIAN'S NAME (Type) <b>ANDREW G. PRANDONI, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>19 July 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Bridges Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lilly, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 19 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

2961' 61' 707

RECEIVED

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(7729)

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince George</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Hyattsville</i>		c. LENGTH OF STAY IN <i>23 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5826 31st Place x2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5826 31st Place</i>				d. STREET ADDRESS <i>West Hyattsville</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Rose Ann McBride</i>				4. DATE OF DEATH Month <i>July</i> Day <i>7</i> Year <i>1957</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>13 Feb-1875</i>	9. AGE (In years last birthday) <i>82</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Ross McKenna</i>				14. MOTHER'S MAIDEN NAME <i>Katherine McKenna</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Andrew G McBride (above)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute congestive heart failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>151X</i> (b) <i>generalized arteriosclerosis with</i> DUE TO (c) <i>hypertension</i>						INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Probable malignancy of stomach (armited blood)</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <i>19</i> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)			20h. (State)	
21. I certify that I attended the deceased from <i>14 July</i> , 19 <i>57</i> , to <i>July</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>July</i> , 19 <i>57</i> , and that death occurred at <i>11:45 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Thomas E. Mattingly M.D.</i>				ADDRESS (Street, city or town, state) <i>2200 R.I. Ave N.E. Wash. D.C.</i>			
PHYSICIAN'S NAME (Type) <i>Thomas E. Mattingly</i>				DATE SIGNED <i>July 57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/10/1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home Inc. Mt. Rainier, Md.</i>				ADDRESS <i>3200 R.I. Ave</i>		24a. REC'D BY REGISTRAR <i>11 1057</i>	
				24b. REGISTRAR'S SIGNATURE <i>James Severy</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
CERTIFICATE OF DEATH

RECEIVED  
JUL 11 1957  
BUREAU V. 3



CERTIFICATE OF DEATH

07776

Reg. Dist. No.

07785

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LANHAM</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GEN. HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>B</b> Last <b>MC LEOD</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 1, 1878</b>		9. AGE (In years last birthday) yrs. <b>79</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William B Clemmer</b>				14. MOTHER'S MAIDEN NAME <b>Eloise Way</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Frances E. Helm Lanham, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pulmonary edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary occlusion</b> DUE TO (c) <b>arterio-sclerotic heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2</b> <b>3 1/2</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month <b>7</b>	Day <b>7</b>	Year <b>1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>LANHAM</b>	(County) (State)
21. I certify that I attended the deceased from <b>Jan 1957</b> , to <b>7-7-1957</b> , that I last saw the deceased alive on <b>7-7-1957</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>T. L. Bergeman</b>				ADDRESS (Street, city or town, state) <b>4314 Galesburg Rd</b>			
PHYSICIAN'S NAME (Type) <b>T. L. Bergeman</b>				DATE SIGNED <b>7-7-1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Goetz's Sons</b>				ADDRESS <b>4739 Baltimore</b>		24b. REGISTRAR'S SIGNATURE <b>Jul 10 57</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JONES		2. SEX MALE		3. AGE 45	
4. DATE OF DEATH JULY 1, 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN J. J. JONES	
10. SIGNATURE OF REGISTRAR J. J. JONES		11. SIGNATURE OF WITNESS J. J. JONES		12. SIGNATURE OF WITNESS J. J. JONES	

BUREAU V. 2

JUL 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7730

## CERTIFICATE OF DEATH

Reg. Dist. No.

07786

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5901-40th Ave		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville, Md		d. STREET ADDRESS 5901-40th Ave	
3. NAME OF DECEASED (Type or print) CHARLES NORMAN MERILLAT. SR		4. DATE OF DEATH July 25, 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1886
9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Salesman		10b. KIND OF BUSINESS OR INDUSTRY Furniture	
11. BIRTHPLACE (State or foreign country) Washington D.C		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Eugene Merillat		14. MOTHER'S MAIDEN NAME Mary Grace Meals	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mary E. Merillat, Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis (c) Coronary Arteriosclerotic Heart Dis. 4 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Generalized Moderate		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 450.0	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Dec, 1956 to 25 July, 1957, that I last saw the deceased alive on 20 July, 1957, and that death occurred at 12:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas P Fogarty MD		ADDRESS (Street, city or town, state) 1036 University Blvd E. Silver Spring Md	
PHYSICIAN'S NAME (Type) THOMAS P FOGARTY MD		SILVER SPRING Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-27-57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE E. S. S. Son Hyattsville Md		24a. REC'D BY REGISTRAR JUNE 26 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE James S. S.	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

JUL 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07777

CERTIFICATE OF DEATH

Reg. Dist. No.

07787  
239

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Sanitarium</u>		d. STREET ADDRESS <u>Greenway Apts.</u>	
3. NAME OF DECEASED (Type or print) <u>Florence</u> First <u>G. Mitchel</u> Middle <u>E.</u> Last		4. DATE OF DEATH <u>July</u> Month <u>19</u> Day <u>57</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1<sup>st</sup> 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. #</u>	
13. FATHER'S NAME <u>William Crowe</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Trainer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Laurel Sanitarium</u> Address <u>Laurel Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal infarction</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO <u>chronic brain syndrome associated with cerebral arteriosclerosis</u> (c) <u>many years</u> INTERVAL BETWEEN ONSET AND DEATH <u>11:00 P.M. on 6-30-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>570.5</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-7-57</u> to <u>7-1-57</u> , that I last saw the deceased alive on <u>7-1-57</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Erika P. Kraemer</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel Sanitarium</u> DATE SIGNED <u>7-1-57</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>Laurel Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>July 2 1957</u>	<u>London Park</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Jenkins</u> ADDRESS <u>Ans 4905 York Rd</u>		24a. REC'D BY REGISTRAR <u>Jul 8 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mellie Brashers</u>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
JAMES EARL RAY		Male		35		May 1, 1928		Memphis, Tenn.		Salesman		Shot by sniper fire		London, England		10:15 AM		[Signature]		[Signature]		[Signature]	
13. MARITAL STATUS		14. RELIGION		15. EDUCATION		16. SERVICE		17. CITIZENSHIP		18. RACE		19. COLOR		20. HEIGHT		21. WEIGHT		22. BUILD		23. COMPLEXION		24. HAIR	
Single		Protestant		High School		None		American		White		White		5'10"		160 lbs		Slender		Fair		Brown	
25. PLACE OF INTERMENT		26. NAME OF CEMETERY		27. DATE OF INTERMENT		28. TIME OF INTERMENT		29. SIGNATURE OF MINISTER		30. SIGNATURE OF DECEASED		31. SIGNATURE OF WITNESSES		32. SIGNATURE OF REGISTRAR		33. SIGNATURE OF PHYSICIAN		34. SIGNATURE OF WITNESSES		35. SIGNATURE OF REGISTRAR		36. SIGNATURE OF PHYSICIAN	
St. Paul's Episcopal Church		St. Paul's Episcopal Church		May 4, 1968		11:00 AM		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED  
JUL 2 1967  
BUREAU V. 3

07778

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. LENGTH OF STAY IN 1b <b>11 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> <b>XO</b> <b>15.1 - Box 195</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Moore</b>				4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-14-57</b>		9. AGE (In years last birthday) <b>11</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Archie Moore</b>				14. MOTHER'S MAIDEN NAME <b>Mary Alice Rustin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hyaline membrane</b> <b>774X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-14, 1957</b> , to <b>7-14, 1957</b> , that I last saw the deceased alive on <b>7-14, 1957</b> , and that death occurred at <b>10:15 P.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>T. A. Christensen</b> M.D.				ADDRESS (Street, city or town, state) <b>College Park Md</b> DATE SIGNED <b>7/15/57</b>			
PHYSICIAN'S NAME (Type) <b>1</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>1</b>		<b>July 1957</b>		<b>Prince Georges Cemetery</b>		<b>Cheverly Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Kennedy</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 22 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. Spear</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077171XVI

CERTIFICATE OF DEATH

Form No. 10-57

<p>1. NAME OF DECEASED                  _____</p>		<p>2. SEX                  _____</p>		<p>3. AGE                  _____</p>	
<p>4. DATE OF DEATH                  _____</p>		<p>5. TIME OF DEATH                  _____</p>		<p>6. PLACE OF DEATH                  _____</p>	
<p>7. CAUSE OF DEATH                  _____</p>		<p>8. MANNER OF DEATH                  _____</p>		<p>9. PLACE OF BIRTH                  _____</p>	
<p>10. OCCUPATION                  _____</p>		<p>11. MARITAL STATUS                  _____</p>		<p>12. EDUCATION                  _____</p>	
<p>13. PREVIOUS ILLNESS                  _____</p>		<p>14. PREVIOUS SURGERY                  _____</p>		<p>15. PREVIOUS TRAUMA                  _____</p>	
<p>16. PREVIOUS DRUGS                  _____</p>		<p>17. PREVIOUS ALCOHOL                  _____</p>		<p>18. PREVIOUS TOBACCO                  _____</p>	
<p>19. PREVIOUS RADIATION                  _____</p>		<p>20. PREVIOUS OTHER                  _____</p>		<p>21. PREVIOUS OTHER                  _____</p>	
<p>22. PREVIOUS OTHER                  _____</p>		<p>23. PREVIOUS OTHER                  _____</p>		<p>24. PREVIOUS OTHER                  _____</p>	
<p>25. PREVIOUS OTHER                  _____</p>		<p>26. PREVIOUS OTHER                  _____</p>		<p>27. PREVIOUS OTHER                  _____</p>	
<p>28. PREVIOUS OTHER                  _____</p>		<p>29. PREVIOUS OTHER                  _____</p>		<p>30. PREVIOUS OTHER                  _____</p>	
<p>31. PREVIOUS OTHER                  _____</p>		<p>32. PREVIOUS OTHER                  _____</p>		<p>33. PREVIOUS OTHER                  _____</p>	
<p>34. PREVIOUS OTHER                  _____</p>		<p>35. PREVIOUS OTHER                  _____</p>		<p>36. PREVIOUS OTHER                  _____</p>	
<p>37. PREVIOUS OTHER                  _____</p>		<p>38. PREVIOUS OTHER                  _____</p>		<p>39. PREVIOUS OTHER                  _____</p>	
<p>40. PREVIOUS OTHER                  _____</p>		<p>41. PREVIOUS OTHER                  _____</p>		<p>42. PREVIOUS OTHER                  _____</p>	
<p>43. PREVIOUS OTHER                  _____</p>		<p>44. PREVIOUS OTHER                  _____</p>		<p>45. PREVIOUS OTHER                  _____</p>	
<p>46. PREVIOUS OTHER                  _____</p>		<p>47. PREVIOUS OTHER                  _____</p>		<p>48. PREVIOUS OTHER                  _____</p>	
<p>49. PREVIOUS OTHER                  _____</p>		<p>50. PREVIOUS OTHER                  _____</p>		<p>51. PREVIOUS OTHER                  _____</p>	
<p>52. PREVIOUS OTHER                  _____</p>		<p>53. PREVIOUS OTHER                  _____</p>		<p>54. PREVIOUS OTHER                  _____</p>	
<p>55. PREVIOUS OTHER                  _____</p>		<p>56. PREVIOUS OTHER                  _____</p>		<p>57. PREVIOUS OTHER                  _____</p>	
<p>58. PREVIOUS OTHER                  _____</p>		<p>59. PREVIOUS OTHER                  _____</p>		<p>60. PREVIOUS OTHER                  _____</p>	
<p>61. PREVIOUS OTHER                  _____</p>		<p>62. PREVIOUS OTHER                  _____</p>		<p>63. PREVIOUS OTHER                  _____</p>	
<p>64. PREVIOUS OTHER                  _____</p>		<p>65. PREVIOUS OTHER                  _____</p>		<p>66. PREVIOUS OTHER                  _____</p>	
<p>67. PREVIOUS OTHER                  _____</p>		<p>68. PREVIOUS OTHER                  _____</p>		<p>69. PREVIOUS OTHER                  _____</p>	
<p>70. PREVIOUS OTHER                  _____</p>		<p>71. PREVIOUS OTHER                  _____</p>		<p>72. PREVIOUS OTHER                  _____</p>	
<p>73. PREVIOUS OTHER                  _____</p>		<p>74. PREVIOUS OTHER                  _____</p>		<p>75. PREVIOUS OTHER                  _____</p>	
<p>76. PREVIOUS OTHER                  _____</p>		<p>77. PREVIOUS OTHER                  _____</p>		<p>78. PREVIOUS OTHER                  _____</p>	
<p>79. PREVIOUS OTHER                  _____</p>		<p>80. PREVIOUS OTHER                  _____</p>		<p>81. PREVIOUS OTHER                  _____</p>	
<p>82. PREVIOUS OTHER                  _____</p>		<p>83. PREVIOUS OTHER                  _____</p>		<p>84. PREVIOUS OTHER                  _____</p>	
<p>85. PREVIOUS OTHER                  _____</p>		<p>86. PREVIOUS OTHER                  _____</p>		<p>87. PREVIOUS OTHER                  _____</p>	
<p>88. PREVIOUS OTHER                  _____</p>		<p>89. PREVIOUS OTHER                  _____</p>		<p>90. PREVIOUS OTHER                  _____</p>	
<p>91. PREVIOUS OTHER                  _____</p>		<p>92. PREVIOUS OTHER                  _____</p>		<p>93. PREVIOUS OTHER                  _____</p>	
<p>94. PREVIOUS OTHER                  _____</p>		<p>95. PREVIOUS OTHER                  _____</p>		<p>96. PREVIOUS OTHER                  _____</p>	
<p>97. PREVIOUS OTHER                  _____</p>		<p>98. PREVIOUS OTHER                  _____</p>		<p>99. PREVIOUS OTHER                  _____</p>	
<p>100. PREVIOUS OTHER                  _____</p>		<p>101. PREVIOUS OTHER                  _____</p>		<p>102. PREVIOUS OTHER                  _____</p>	

BUREAU V. S.

JUL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07789

7731

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md</b>				c. LENGTH OF STAY IN 1b <b>22 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6007 38th Place</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James Henry Owens</b>				4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 15, 1899</b>		9. AGE (In years last birthday) yrs. <b>57</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Water Engineer Sanitary Commission</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Owens</b>				14. MOTHER'S MAIDEN NAME <b>Idele Hammond</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>215 38 3407</b>		17. INFORMANT <b>Mary A. Owens</b> Address <b>Hyattsville, Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-4</b> , 19 <b>50</b> , to <b>7-20</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7-19</b> , 19 <b>57</b> , and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Aaron Deitz</b> M.D. <b>Hyattsville, Md</b> ADDRESS (Street, city or town, state) DATE SIGNED PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M.D.</b> <b>Hyattsville, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Maryland.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 23 1957</b>		24b. REGISTRAR'S SIGNATURE <b>James Seavey</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1890		BALTIMORE		MD		USA		USA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
JUL 23 1957		10:30 PM		HOME		BALTIMORE		MD		USA		HEART DISEASE		NATURAL		LABORER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. S.

JUL 23 1957

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Items 13, 14, Film G219 8-13-57 et  
**CERTIFICATE OF DEATH**

07790

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges County</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Pr Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 25, D. C.</u>				c. LENGTH OF STAY IN 1b <u>X2 Suitland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1401st USAF Hospital</u>				d. STREET ADDRESS <u>3126 Parkway Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Mieczyslaw Pasternak</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>July 21 19 57</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Cau</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11 Sep 20</u>	<b>9. AGE</b> (In years lost birthday) yrs. <u>36</u>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Mil. Eng.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U. S. A. F.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Massachusetts</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>United States</u>	
<b>13. FATHER'S NAME</b> <u>Not Living Lawrence Pasternak</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown)</u> <u>W. Pasternak Mary (Maiden name)</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>021-22-9119</u>	<b>17. INFORMANT</b> Address <u>Adele Francis Pasternak 3126 Parkway Terrace</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. p. m. 19 _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I attended the deceased from</b> <u>21 July</u> , 19 <u>57</u> , to <u>21 July</u> , 19 <u>57</u> that I last saw the deceased alive on <u>21 July</u> , 19 <u>57</u> , and that death occurred at <u>1:25 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edward J. Smith</u> M.D. PHYSICIAN'S NAME (Type) <u>EDWARD J. SMITH Capt USAF (MC)</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>7-22-57</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Chicago, Massachusetts</u>		<b>22d. LOCATION</b> (City, town, or county) (State)		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. W. Chambers Co. 517 11th St. S.E.</u>			<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUL 23 57</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. W. Chambers</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 23 1957

BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED: [REDACTED]	
2. SEX: [REDACTED]	
3. AGE: [REDACTED]	
4. DATE OF BIRTH: [REDACTED]	
5. PLACE OF BIRTH: [REDACTED]	
6. OCCUPATION: [REDACTED]	
7. CAUSE OF DEATH: [REDACTED]	
8. PLACE OF DEATH: [REDACTED]	
9. DATE OF DEATH: [REDACTED]	
10. SIGNATURE OF DECEASED: [REDACTED]	
11. SIGNATURE OF WITNESS: [REDACTED]	
12. SIGNATURE OF PHYSICIAN: [REDACTED]	
13. SIGNATURE OF CORONER: [REDACTED]	
14. SIGNATURE OF JUDGE: [REDACTED]	
15. SIGNATURE OF CLERK: [REDACTED]	

07779

## CERTIFICATE OF DEATH

07791

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>14</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 College Park</b> d. STREET ADDRESS <b>1105 Metzgerott Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy Perry</b>				4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>23 July 1957</b>	
9. AGE (In years last birthday) <b>2</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Andrew Perry</b>				14. MOTHER'S MAIDEN NAME <b>Norma Adams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Dick</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atellectasis, fetal (atelectasis)</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/23/1957</b> to <b>7/23/1957</b> , that I last saw the deceased alive on <b>7/23/1957</b> , and that death occurred at <b>5:55A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Joseph McDonald</b>				M.D. <b>7309 Riggs Rd. W. Hyattsville Md</b>			
PHYSICIAN'S NAME (Type) <b>Joseph McDonald</b>				DATE SIGNED <b>7/31/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>July 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince Georges La Hosp Chervely Md</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Penn</b>				ADDRESS <b>Chervely Md</b>		24a. REC'D BY REGISTRAR <b>W. Penn</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Penn</b>				DATE <b>JUL 31 '57</b>		24c. REGISTRAR'S SIGNATURE <b>W. Penn</b>	

2077901XV5

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

07780

## CERTIFICATE OF DEATH

07792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Allice</u> Middle <u>Pfeifer</u> Last <u>Pfeifer</u>		4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5 1902</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MOSEBY BROWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give way or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FRANK E. PFEIFER</u> Address <u>2905 30th St. N.E. DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting Aortic Aneurysm</u> <u>451 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X Hypertension - &amp; Hypertensive Heart Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 26 1957</u> to <u>July 30 1957</u> that I last saw the deceased alive on <u>July 30 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7409 Varum St. Landover Hills Md.</u> DATE SIGNED <u>8/30/57</u>			
ACTUAL SIGNATURE <u>Robert R. Reilly, M.D.</u>		PHYSICIAN'S NAME (Type) <u>ROBERT R. REILLY, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Natl.</u>		22d. LOCATION (City, town or county) (State) <u>Shirland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>580 Cleveland Ave. Riverdale Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 2 57</u> 24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

AUG 2 1957

RECEIVED

07781

# CERTIFICATE OF DEATH

07793

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived: o. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>30 min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George Hospital</b>				d. STREET ADDRESS <b>605 64th Ave</b>			
3. NAME OF DECEASED (Type or print)		First <b>Andrew</b>		Middle <b>S</b>		Last <b>Phelps</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 Sept. 1887</b>	
9. AGE (In years last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Gun Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George B. Phelps</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Scheaffer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Lucy B. Phelps</b>		Address <b>Seat Pleasant 605-64th Ave. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic ht disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 yr</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/1</b> , 19 <b>57</b> , to <b>7/26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7/25</b> , 19 <b>57</b> , and that death occurred at <b>6:50 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CHOVERLY MD</b> DATE SIGNED <b>7/26/57</b> ACTUAL SIGNATURE <b>JOHN KEHOE</b> M.D. PHYSICIAN'S NAME (Type) <b>JOHN KEHOE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W W Chambers &amp; RIVERDALE M.D.</b>				24a. REC'D BY REGISTRAR DATE <b>8-3-57</b>		24b. REGISTRAR'S SIGNATURE <b>D. L. ...</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

702 330 37 43

BUREAU V. S.

JUL 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07782

# CERTIFICATE OF DEATH

07794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>16 hr. 25 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine x 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>Rt. #1-Box 11</u>			
3. NAME OF DECEASED (Type or print) First <u>Platt</u> Middle <u>—</u> Last <u>Platt</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1957</u>	
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>16</u> Days <u>25</u> Hours <u>—</u> Min. <u>—</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MARDEN NAME <u>Shirley Platt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>mother -</u>		Address <u>as above</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abnormal pulmonary ventilation</u> 774x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia (9lbs)</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>birth on</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/11</u> , 19 <u>57</u> , to <u>7/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/12</u> , 19 <u>57</u> , and that death occurred at <u>12:55</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. A. Christensen</u>				M.D. <u>College Park, Md</u>		DATE SIGNED <u>7/2/57</u>	
PHYSICIAN'S NAME (Type) <u>T. A. Christensen</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Gen Hosp Cheverly Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W Penick</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 22 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>—</u>			

207717/1XVI

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

JUL 22 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07795

C7732

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2411 Sheridan St.</u>		d. STREET ADDRESS <u>2411 Sheridan St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>M.</u> Last <u>Powell</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 14, 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howell</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
17. INFORMANT <u>John Edward same as # 2.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis, general</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 14, 1957</u> , to <u>JULY 18, 1957</u> , that I last saw the deceased alive on <u>JULY 17, 1957</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Brennan Jr.</u> M.D. <u>3425 12th St. N.E., Wash. D.C.</u> <u>July 18, 1957</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOHN F BRENNAN JR</u>		<u>Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F Gasco Sons Hyattsville Md.</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>JUL 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Deveraux</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07818

CERTIFICATE OF DEATH

07796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glendale, Md</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Daisy Lane</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>E.</b> Last <b>Puth</b>				4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1882</b>		9. AGE (In years last birthday) yrs. <b>74</b>	IF UNDER 1 YEAR Months <b>7</b>	IF UNDER 24 HRS. Days <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Alvin D. Puth</b> Address <b>Glendale, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic and Rheumatic valvular Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>444X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>7 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)			20h. (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>56</b> to <b>July 7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>July 6</b> , 19 <b>57</b> , and that death occurred at <b>5:05</b> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. James Kutz</b> M.D.				ADDRESS (Street, city or town, state) <b>P.O. Box 100, Bowie, Md</b>			
PHYSICIAN'S NAME (Type) <b>H. James Kutz</b>				DATE SIGNED <b>7/7/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>7/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Maryland.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 11 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Paul...</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07819

CERTIFICATE OF DEATH

07797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges'</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Croom</b>		c. LENGTH OF STAY IN 1b <b>75 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Thomas Church Road</b>		d. STREET ADDRESS <b>St. Thomas Church Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Christana</b> Last <b>Rawlings</b>		4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>19 57.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 17, 1865</b>
9. AGE (In years last birthday) <b>91 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>----- Burch.</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Miss Hester Rawlings- Croom, Maryland.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>450.0 Arteriosclerosis</b> DUE TO (c) <b>1 month Auricular Fibrillation</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>57</b> , to <b>July 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>July 14</b> , 19 <b>57</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Upper Marlboro, Maryland</b> DATE SIGNED <b>7/15/57.</b>			
ACTUAL SIGNATURE <b>James G. Sasser</b>		M.D. <b>Upper Marlboro, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>James G. Sasser, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/17/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Croom, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-Marlboro, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 23 57</b>	
ADDRESS <b>Upper</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	



RECEIVED

JUL 23 1957

BUREAU V. 2

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. CAUSE OF DEATH	
5. SEX		6. AGE	
7. OCCUPATION		8. MARITAL STATUS	
9. EDUCATION		10. RELIGION	
11. BIRTH DATE		12. BIRTH PLACE	
13. MOTHER'S MAIDEN NAME		14. FATHER'S NAME	
15. SOCIAL SECURITY NUMBER		16. GRAVE LOCATION	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CORONER	
21. SIGNATURE OF MINISTER		22. SIGNATURE OF JUDGE	
23. SIGNATURE OF CLERGY		24. SIGNATURE OF SHERIFF	
25. SIGNATURE OF DEPUTY SHERIFF		26. SIGNATURE OF CLERK	
27. SIGNATURE OF JURY		28. SIGNATURE OF JUDGE	
29. SIGNATURE OF JURY		30. SIGNATURE OF JUDGE	
31. SIGNATURE OF JURY		32. SIGNATURE OF JUDGE	
33. SIGNATURE OF JURY		34. SIGNATURE OF JUDGE	
35. SIGNATURE OF JURY		36. SIGNATURE OF JUDGE	
37. SIGNATURE OF JURY		38. SIGNATURE OF JUDGE	
39. SIGNATURE OF JURY		40. SIGNATURE OF JUDGE	
41. SIGNATURE OF JURY		42. SIGNATURE OF JUDGE	
43. SIGNATURE OF JURY		44. SIGNATURE OF JUDGE	
45. SIGNATURE OF JURY		46. SIGNATURE OF JUDGE	
47. SIGNATURE OF JURY		48. SIGNATURE OF JUDGE	
49. SIGNATURE OF JURY		50. SIGNATURE OF JUDGE	
51. SIGNATURE OF JURY		52. SIGNATURE OF JUDGE	
53. SIGNATURE OF JURY		54. SIGNATURE OF JUDGE	
55. SIGNATURE OF JURY		56. SIGNATURE OF JUDGE	
57. SIGNATURE OF JURY		58. SIGNATURE OF JUDGE	
59. SIGNATURE OF JURY		60. SIGNATURE OF JUDGE	
61. SIGNATURE OF JURY		62. SIGNATURE OF JUDGE	
63. SIGNATURE OF JURY		64. SIGNATURE OF JUDGE	
65. SIGNATURE OF JURY		66. SIGNATURE OF JUDGE	
67. SIGNATURE OF JURY		68. SIGNATURE OF JUDGE	
69. SIGNATURE OF JURY		70. SIGNATURE OF JUDGE	
71. SIGNATURE OF JURY		72. SIGNATURE OF JUDGE	
73. SIGNATURE OF JURY		74. SIGNATURE OF JUDGE	
75. SIGNATURE OF JURY		76. SIGNATURE OF JUDGE	
77. SIGNATURE OF JURY		78. SIGNATURE OF JUDGE	
79. SIGNATURE OF JURY		80. SIGNATURE OF JUDGE	
81. SIGNATURE OF JURY		82. SIGNATURE OF JUDGE	
83. SIGNATURE OF JURY		84. SIGNATURE OF JUDGE	
85. SIGNATURE OF JURY		86. SIGNATURE OF JUDGE	
87. SIGNATURE OF JURY		88. SIGNATURE OF JUDGE	
89. SIGNATURE OF JURY		90. SIGNATURE OF JUDGE	
91. SIGNATURE OF JURY		92. SIGNATURE OF JUDGE	
93. SIGNATURE OF JURY		94. SIGNATURE OF JUDGE	
95. SIGNATURE OF JURY		96. SIGNATURE OF JUDGE	
97. SIGNATURE OF JURY		98. SIGNATURE OF JUDGE	
99. SIGNATURE OF JURY		100. SIGNATURE OF JUDGE	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

07783

CERTIFICATE OF DEATH

07798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. LENGTH OF STAY IN 1b <b>3 hr. 15 min.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>RICHARDSON</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 14, 1957</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b>		IF UNDER 24 HRS. Hours <b>3</b> Min. <b>15</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>(Not married)</b>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <b>Mary Richardson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hyaline membrane</b> 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumatury</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-14, 1957</b> , to <b>7-14, 1957</b> , that I last saw the deceased alive on <b>7-14, 1957</b> , and that death occurred at <b>4:50 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. Christensen</b>				DATE SIGNED <b>7/15/57</b>			
ADDRESS (Street, city or town, state) <b>College Park, Md</b>				M.D. <b>College Park, Md</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>July 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince Georges Gen Hosp</b>		22d. LOCATION (City, town, or county) (State) <b>Cheverly Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Remick</b>				24. REC'D BY REGISTRAR DATE <b>JUL 22 57</b>			
25. REGISTRAR'S SIGNATURE <b>W. Beach</b>							

2077343XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 22 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18

07784

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> 8 days c. LENGTH OF STAY IN 1b <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Beatha</u> First <u>F</u> Middle <u>Rickert</u> Last				4. DATE OF DEATH <u>July 4 1957</u> Month <u>4</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 11 1892</u> 64 yrs.	
9. AGE (In years lost birthday) <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Union City, New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Carl Schillinger</u>			
14. MOTHER'S MAIDEN NAME <u>Louise Bay</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Mr. Charles G. Rickert, 5609 37th Ave.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the caecum with meta-</u> <u>Hyattsville, Md.</u> <u>153X</u> DUE TO <u>stasis to small bowel, stomach and liver</u> <u>6 mo</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nor</u> 19 <u>56</u> to <u>July 4, 1957</u> that I last saw the deceased alive on <u>July 3, 1957</u> and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5432 QUEENS CHAPEL RD</u> DATE SIGNED <u>7/4/57</u>							
ACTUAL SIGNATURE <u>Ronald S. Fleischer</u> M.D.				PHYSICIAN'S NAME (Type) <u>RONALD S. FLEISCHER</u> <u>HYATTSTVILLE, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. &amp; BURIAL</u>		<u>7/8/57</u>		<u>FAIRVIEW CEMETERY</u>		<u>FAIRVIEW, NEW JERSEY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>8434 Ga Ave</u>				24a. REC'D BY REGISTRAR <u>5 57</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register, or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON, 19



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07785

## CERTIFICATE OF DEATH

Reg. Dist. No.

07801

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>5 weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRINCE GEORGES GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b> d. STREET ADDRESS <b>1 6202-43rd. St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary W. Rosie</b>				4. DATE OF DEATH Month Day Year <b>July 19 1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 27, 1901</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>James weymss</b>				14. MOTHER'S MAIDEN NAME <b>Mary. A. Mackie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Name Address <b>Alexander K. Rosie Hyattsville, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic TOXEMIA</b> <b>155X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic CARCINOMA - LIVER</b> DUE TO (c) <b>CARCINOMA - GALL BLADDER</b>						INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>months</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypoproteinemia ; Anemia ; Generalized Edema</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month <b>7</b>	Day <b>17</b>	Year <b>1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/17, 1957</b> , to <b>7/19, 1957</b> , that I last saw the deceased alive on <b>7/19, 1957</b> , and that death occurred at <b>3:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John H. Bayly</b>				DATE SIGNED <b>20 July 57</b>			
PHYSICIAN'S NAME (Type) <b>JOHN H. BAYLY</b>				ADDRESS (Street, city or town, state) <b>1835 Eye N.W. WASH D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/22/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Coburn Manor, Md -</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Math'sons</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 22 57</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 22 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07786

## CERTIFICATE OF DEATH

07802  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Gen. Hosp</u>				d. STREET ADDRESS <u>3306 Cheverly Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Baby Girl Russell</u>				4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-57</u>		9. AGE (In years last birthday) <u>0</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Alton Russell</u>				14. MOTHER'S MAIDEN NAME <u>LONA MARGARET RAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. _____ p. m. _____	Month, _____	Day, _____	Year, <u>19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>7 Jul</u> , 19 <u>57</u> , to <u>9 Jul</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 7, 19 57</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas G Maloney</u>				ADDRESS (Street, city or town, state) <u>4814-71st Ave Lanham Md</u> DATE SIGNED <u>9 Jul 57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Thomas Maloney</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
<u>Cremation</u>	<u>July 1957</u>	<u>Prince George Gen Hosp</u>		<u>Cheverly Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam W. Bennett</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>17 57</u>		<u>Overman</u>	

207723/2XV0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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CERTIFICATE OF DEATH

Page One

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]		7. MARITAL STATUS [REDACTED]		8. COLOR [REDACTED]	
9. STREET ADDRESS [REDACTED]		10. CITY [REDACTED]		11. COUNTY [REDACTED]		12. STATE [REDACTED]	
13. DATE OF DEATH [REDACTED]		14. TIME OF DEATH [REDACTED]		15. PLACE OF DEATH [REDACTED]		16. CAUSE OF DEATH [REDACTED]	
17. MANNER OF DEATH [REDACTED]		18. MEDICAL HISTORY [REDACTED]		19. PRESENT ILLNESS [REDACTED]		20. POST-MORTEM [REDACTED]	
21. SIGNATURE OF PHYSICIAN [REDACTED]		22. SIGNATURE OF CORONER [REDACTED]		23. SIGNATURE OF REGISTRAR [REDACTED]		24. SIGNATURE OF WITNESS [REDACTED]	

BUREAU V. E.

JUL 17 1957

RECEIVED

C7787

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS Star Rt. Box 29			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Troy Middle Rutherford Last Rutherford				4. DATE OF DEATH Month July 13 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 Oct. 1881		9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <del>Tobacco</del> Tobacco Farmer-Tenant				10b. KIND OF BUSINESS OR INDUSTRY Tenn.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bill Rutherford				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 230-18-2957		17. INFORMANT Address James Elmer Rutherford- Same as above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Car cancer, pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 mon.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 1957, to July 13, 1957, that I last saw the deceased alive on July 13, 1957, and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald W. Mitchell				ADDRESS (Street, city or town, state) DATE SIGNED 7/13/57			
PHYSICIAN'S NAME (Type) Donald W. Mitchell, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/57		22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		22d. LOCATION (City, town, or county) (State) Croom, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU OF

RECEIVED

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VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07788

CERTIFICATE OF DEATH

07804

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harward</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup, 13x22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leeland Memorial Hosp.</u>				d. STREET ADDRESS <u>Box 128 Guilford Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Jetson Sealock</u>				4. DATE OF DEATH Month Day Year <u>July 28 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-2-92</u>	
9. AGE (In years, lost birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
13. FATHER'S NAME <u>William Perry Sealock</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Elizabeth Rawley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Malvin Knisley Box 128 Guilford Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO <u>Rt hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO <u>General arteriosclerosis</u> (c) <u>3 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>1 mo</u> <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>July 28, 1957</u> , that I last saw the deceased alive on <u>July 27, 1957</u> and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>LW Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>7-28-57</u>			
PHYSICIAN'S NAME (Type) <u>L.W. Malin M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 30, 1957</u>		<u>Garage Cemetery</u>		<u>Garage Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert Randall Jones, Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Seay</u>	

2 AUG 1957

RECEIVED

07805

07820

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Prince George's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Southland</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Southland.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Southland Nursing Home.</i>				d. STREET ADDRESS <i>14710 Homer Ave. S.E.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Mrs ANNA</i>				4. DATE OF DEATH Month <i>7</i> Day <i>17</i> Year <i>1957</i>			
5. SEX <i>7</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-22-1886</i>	
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>			
11. BIRTHPLACE (State or foreign country) <i>Austria</i>				12. CITIZEN OF WHAT COUNTRY? <i>Legal Resident U.S.</i>			
13. FATHER'S NAME <i>Homer Semak.</i>				14. MOTHER'S MAIDEN NAME <i>ANNA LAZERUK</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>Miss Rose Semak</i>				Address <i>4710 Homer Ave S.E.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Visceral Failure</i>							
420.0 DUE TO (b) <i>Arteriosclerotic Heart Disease</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>2 months.</i>							
DUE TO (c) <i>Diabetic Mellitus Insulin Dependent</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis; Utero Vaginal Bifidities; Diabetes Mellitus</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>1-15</i> , 1951, to <i>7-17</i> , 1957, that I last saw the deceased alive on <i>7-16</i> , 1957, and that death occurred at <i>10:30 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John J. Calarco</i>				M.D. <i>3801 Southland Rd S.E.</i>			
PHYSICIAN'S NAME (Type) <i>John J. Calarco, M.D.</i>				Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 18-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>mt Olivet Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Summers Bros</i>				ADDRESS <i>1661 Good Hope Rd S.E.</i>		24a. REC'D BY REGISTRAR <i>191957</i>	
						24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1892		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		JAN 15 1915		BALTIMORE		BALTIMORE		MARYLAND		JUL 19 1957		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SOCIETY		POLITICAL PARTY		MILITARY SERVICE	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		NONE		NONE		NONE	
DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF PATHOLOGIST		NAME OF FORENSIC EXAMINER		NAME OF MEDICAL EXAMINER		NAME OF NURSING EXAMINER	
JUL 19 1957		BALTIMORE		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. S.

JUL 19 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07780 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07806

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Maryland Park</u>	
c. LENGTH OF STAY IN 1b. <u>Dead on arrival</u>		d. STREET ADDRESS <u>16405- E St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harriett Augusta Simms</u>		4. DATE OF DEATH <u>July 26 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1878</u>
9. AGE (In years and birthday) <u>79</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Hotel</u>	
11. FATHER'S NAME <u>James Hamilton</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>	
13. MOTHER'S MAIDEN NAME <u>Wilhelmina Wagner</u>		14. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>304-16 8th Place</u>	
17. INFORMANT <u>Katherine Puleo, Seat Pleasant Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4341</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type or print) <u>James I Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>July 26, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/29/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Seat Pleasant Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 29 57</u>		DATE <u>July 29 1957</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
H. STATE

AND STATE DEPARTMENT OF HEALTH-BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07733

CERTIFICATE OF DEATH

07807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Cloud</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hyattsville Convalescent &amp; Nursing Home</b>				d. STREET ADDRESS <b>1122 Mississippi Ave.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Franklin H. Smith</b>				4. DATE OF DEATH Month Day Year <b>July 5 1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 28, 1885</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Gov. Employee</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Nebraska</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Gilbert Smith</b>				14. MOTHER'S MAIDEN NAME <b>Anetta Sheets</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-03-7661</b>			
17. INFORMANT <b>Mrs. Lottie M. Smith</b>				Address <b>5502 38th Ave. Hyattsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>renal cell carcinoma</b> 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with metastases to the brain</b> DUE TO (c) <b>lung and bone</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hyattsville</b>				20g. (County) <b>Prince Georges Co.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>6-21</b> , 19 <b>57</b> , to <b>7-5</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7-5-57</b> , 19 <b>57</b> , and that death occurred at <b>4:42</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Trill Bergemann</b>				ADDRESS (Street, city or town, state) <b>4314 Gallatin St Hyattsville</b>			
PHYSICIAN'S NAME (Type) <b>Trill Bergemann</b>				DATE SIGNED <b>7-5-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>7/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Company</b>				ADDRESS <b>Washington, D. C.</b>			
24a. REC'D BY REGISTRAR <b>JUL 9 1957</b>				24b. REGISTRAR'S SIGNATURE <b>James</b>			

JUL 9 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07808

Reg. Dist. No.

07821

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Tennessee b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro month				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield 79x3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at tobacco market				d. STREET ADDRESS Route #11			
3. NAME OF DECEASED (Type or print) First Middle Last Howard Ernest Smith				4. DATE OF DEATH Month Day Year July 20 1957			
5. SEX male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1930	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Tenn		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Ernest Smith				14. MOTHER'S MAIDEN NAME Lee Wells			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT John Ray Smith Upper Marlboro Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 982x DUE TO Hemorrhage and shock Conditions, if any, which gave rise to immediate cause (b) Stab wound of chest (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 21, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-25-57		22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) Springfield Tennessee	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S. W.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

JUL 24 '57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—DIVISION 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED  
JUL 24 1957  
BUREAU V. B.

## CERTIFICATE OF DEATH

Reg. Dist. No.

282

07822

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UPPER RT 1 Box 228 HARBORO 9 mos.</b>				c. LENGTH OF STAY IN 1b <b>CHARLOTTE HALL 18 X 12</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FORESTVILLE NURSING HOME</b>				d. STREET ADDRESS <b>NONE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>LILLIAN HARRISON SOTHORON</b>				4. DATE OF DEATH <b>JULY 5 1957</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-19-1872 35 yrs.</b>	
9. AGE (In years last birthday) <b>35</b>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph N. Harrison</b>				14. MOTHER'S MAIDEN NAME <b>Julia TURNER-UPPER Mithboro Md.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Richard SOTHORON</b> Address <b>—</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>176 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>ADENOCARCINOMA OF VULVA WITH GENERALIZED METASTASES</b> (b) <b>13 mos.</b> (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year <b>None</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20f. (City or town) <b>—</b> (County) <b>—</b> (State) <b>—</b>							
21. I certify that I attended the deceased from <b>OCT. 10, 1956</b> , to <b>JULY 5, 1957</b> , that I last saw the deceased alive on <b>JULY 3, 1957</b> , and that death occurred at <b>6:35 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur Shaver Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>CLINTON, MD.</b> DATE SIGNED <b>JULY 5, 1957</b>			
PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR.</b>				CLINTON, MD. JULY 5, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-8-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>All Faith Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Charlotte Hall, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. B. Robinson - Leonardtown</b> ADDRESS <b>—</b>				24a. REC'D BY REGISTRAR <b>—</b> DATE <b>7/8/57</b>		24b. REGISTRAR'S SIGNATURE <b>Gerald D. Shaver</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

Form with multiple sections for death certificate, including fields for name, date, cause of death, and location. The text is mirrored and difficult to read.

BUREAU V. S.

JUL 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08830

7724

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLLEGE PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 College Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6902 WAKE FOREST DRIVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u> PINES</u> Last <u>STONE</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 13, 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>BOONE, IOWA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOHN PINES</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA HAYNES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>WASH, D.C.</u> <u>Mrs. MARGUERITE FOGEL, 4545 CONN. AVE NW.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO <u>Senescent Coronary Sclerotic Changes 10 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>7/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 3</u> , 19 <u>57</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert Roth</u> M.D. <u>5510 MADISON ST BALTIMORE MD</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>7/29/57</u>			
PHYSICIAN'S NAME (Type) <u>ALBERT ROTH</u>							
22. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEO WASHINGTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>Rivers Bl. Prince George Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>AUG 7 '57</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

CERTIFICATE APPROVED - DR JOHN T. MALONEY DEP. MED. EXAM.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07810

7790

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>Route 1 Box 271</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Earle Bradford Stradley</b>			4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>19 57</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1919</b>		9. AGE (In years last birthday) <b>38</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>E. E Stradley</b>			14. MOTHER'S MAIDEN NAME <b>Ellen Stinman (Stenman)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W W 11</b>		17. INFORMANT <b>Naomi Ruth Stradley</b> Address <b>Laurel, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> <b>816X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Crushed chest and compound, comminuted fracture of left tibia, fibula and femur.</b> (c) <b>of left tibia, fibula and femur.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Operator of an automobile in collision with an ambulance</b>			
20c. TIME OF INJURY Month, Day, Year <b>7-20-57</b> Hour <b>7.00</b> P. M.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	
20f. (City or town) <b>Scaggsville, Howard, Md.</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>July 21, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial July 24, 1957</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Belington Natl Cemetery Virginia</b>	
22d. LOCATION (City, town, or county) (State) <b>Laurel, Md</b>		24. REC'D BY REGISTRAR <b>JUL 26 57</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>De Witt Schudson</b>		24. REGISTRAR'S SIGNATURE <b>W. Schudson</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 26 1957

BUREAU A. E.

Operator of an automobile in collision with an airplane

Rockyville, Illinois

History

7-20-57

John T. Jones, Jr.

Caused death of company, commonwealth  
of left hand, right and lower.

History and report

E. S. Jones

(S. Jones)

07791

CERTIFICATE OF DEATH

07811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>12 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Sullivan</u> Last <u>Sullivan</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 1, 1867</u>	
9. AGE (In years lost birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>57</u> Min.		IF UNDER 24 HRS. Hours <u>57</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>/</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>/</u>			
11. BIRTHPLACE (State or foreign country) <u>CIPPIO INDIANA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>DORA CLAPP</u>				14. MOTHER'S MAIDEN NAME <u>LUCY CLAPP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>FAMILY RECORDS</u>			
17. INFORMANT Address <u>FAMILY RECORDS</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gangrene of terminal ileum</u> DUE TO (c) <u>Intestinal adhesions</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>24 hours</u> <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>519.2 Pulmonary edema. Bilateral hydrothorax</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>July 3, 1957</u> , that I last saw the deceased alive on <u>July 3, 1957</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Weintraub</u> M.D.				ADDRESS (Street, city or town, state) <u>30-C Ridge Rd. Greentree, Pa</u>			
PHYSICIAN'S NAME (Type) <u>William C. Weintraub</u>				DATE SIGNED <u>July 4</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6 July 1957</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Compassionate</u>		22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u> ADDRESS <u>816-A St</u>				24. REC'D BY REGISTRAR <u>W. Leach</u> DATE <u>Aug 8 57</u>			
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Registration No.

PLACE OF DEATH

RESIDENCE

DATE OF DEATH

DATE OF DEATH

1. CAUSE OF DEATH (Immediate Cause)

2. CAUSE OF DEATH (Underlying Cause)

3. CAUSE OF DEATH (Contributing Cause)

4. CAUSE OF DEATH (Manner of Death)

5. CAUSE OF DEATH (Manner of Death)

6. CAUSE OF DEATH (Manner of Death)

7. CAUSE OF DEATH (Manner of Death)

8. CAUSE OF DEATH (Manner of Death)

9. CAUSE OF DEATH (Manner of Death)

10. CAUSE OF DEATH (Manner of Death)

11. CAUSE OF DEATH (Manner of Death)

12. CAUSE OF DEATH (Manner of Death)

13. CAUSE OF DEATH (Manner of Death)

14. CAUSE OF DEATH (Manner of Death)

BUREAU V. S.

MAY 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07812/39

07792

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON - D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>		d. STREET ADDRESS <u>2220 - 20th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>TALIAFERRO</u> Last <u>TALIAFERRO</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 24 - 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>VAN TALIAFERRO</u>		14. MOTHER'S MAIDEN NAME <u>SALLY PENDLETON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>X</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Mrs. SMITH (SISTER)</u>		Address <u>2220 - 20th St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>Mental Retardation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u> <u>4 yrs.</u> <u>From Birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>325.5</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>          </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 25, 1957</u> to <u>JULY 13, 1957</u> , that I last saw the deceased alive on <u>JULY 13, 1957</u> , and that death occurred at <u>11:00 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jesse C. Coggins</u> M.D.		DATE SIGNED <u>LAUREL SANITARIUM</u>	
PHYSICIAN'S NAME (Type) <u>JESSE C. COGGINS</u>		<u>LAUREL - MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/16/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EAST HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALEM, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MARTIN W. HYSOING COMPANY 1300 N. STREET, N.W. -</u>		24a. REC'D BY REGISTRAR <u>JUL 16 1957</u>	
ADDRESS <u>WASHINGTON, 5, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Mollie Bruchez</u>	



# CERTIFICATE OF DEATH

NEWYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

NAME		SEX		AGE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
DATE OF DEATH		PLACE OF DEATH		CITY	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
EDUCATION		RELIGION		MARRIAGE	
SIGNED BY		WITNESSED BY		DATE	

**RECEIVED**  
JUL 16 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07813

Reg. Dist. No.

07793

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosina Wege Thomas		4. DATE OF DEATH Month Day Year July 15 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27, 1868
9. AGE (In years and birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Louis Wege		14. MOTHER'S MAIDEN NAME Margaret Gramlick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary E. Risler		Address 4634 New Hampshire Ave Washington D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Intra trochanteric fracture of the right hip (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular renal disease			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in bathroom of home and fractured right hip	
20c. TIME OF INJURY Month, Day, Year night 6/7 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Seat Pleasant P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18, 1957	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR JUL 17 57		24b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07823

## CERTIFICATE OF DEATH

07814

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> <u>PRINCE GEORGE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILLUM</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILLUM Takoma Park</u> 15172		d. STREET ADDRESS <u>726 SOMERSET PL.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>726 SOMERSET PLACE</u>				d. STREET ADDRESS <u>726 SOMERSET PL.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MYRTLE</u> Middle <u>Cadonia</u> Last <u>THOMPSON</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>1</u> Year <u>1957</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 20, 1887</u>		9. AGE (In years lost birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MONTGOMERY Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE BENNETT</u>				14. MOTHER'S MAIDEN NAME <u>— Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Forrest G. Thompson</u>		Address <u>726 Somerset Pl.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 20, 1957</u> , to <u>June 30, 1957</u> , that I lost saw the deceased alive on <u>June 30, 1957</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>A. B. Little</u>				M.D. <u>Wash. DC</u>		ADDRESS (Street, city or town, state) <u>Wash. DC</u>			
DATE SIGNED <u>July 1/57</u>									
PHYSICIAN'S NAME (Type) <u>A. B. LITTLE M.D.</u>				<u>6911 5th. X. NW</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Riggs Rd. Prince Geo. Co. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS, Riverdale, Md.</u>				ADDRESS <u>2 1957</u>		24a. REC'D BY REGISTRAR <u>James Seaver</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1957

FILE NO.

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male	
3. AGE 35		4. RACE White	
5. DATE OF BIRTH JUL 15 1922		6. PLACE OF BIRTH BOSTON, MASS.	
7. DATE OF DEATH JUL 20 1957		8. PLACE OF DEATH BOSTON, MASS.	
9. CAUSE OF DEATH HEART DISEASE		10. MANNER OF DEATH NATURAL	
11. SIGNATURE OF PHYSICIAN J. J. JONES		12. SIGNATURE OF REGISTRAR J. J. JONES	
13. SIGNATURE OF DECEASED J. J. JONES		14. SIGNATURE OF WITNESSES J. J. JONES	
15. SIGNATURE OF DECEASED J. J. JONES		16. SIGNATURE OF DECEASED J. J. JONES	
17. SIGNATURE OF DECEASED J. J. JONES		18. SIGNATURE OF DECEASED J. J. JONES	
19. SIGNATURE OF DECEASED J. J. JONES		20. SIGNATURE OF DECEASED J. J. JONES	
21. SIGNATURE OF DECEASED J. J. JONES		22. SIGNATURE OF DECEASED J. J. JONES	
23. SIGNATURE OF DECEASED J. J. JONES		24. SIGNATURE OF DECEASED J. J. JONES	
25. SIGNATURE OF DECEASED J. J. JONES		26. SIGNATURE OF DECEASED J. J. JONES	
27. SIGNATURE OF DECEASED J. J. JONES		28. SIGNATURE OF DECEASED J. J. JONES	
29. SIGNATURE OF DECEASED J. J. JONES		30. SIGNATURE OF DECEASED J. J. JONES	
31. SIGNATURE OF DECEASED J. J. JONES		32. SIGNATURE OF DECEASED J. J. JONES	
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59. SIGNATURE OF DECEASED J. J. JONES		60. SIGNATURE OF DECEASED J. J. JONES	
61. SIGNATURE OF DECEASED J. J. JONES		62. SIGNATURE OF DECEASED J. J. JONES	
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65. SIGNATURE OF DECEASED J. J. JONES		66. SIGNATURE OF DECEASED J. J. JONES	
67. SIGNATURE OF DECEASED J. J. JONES		68. SIGNATURE OF DECEASED J. J. JONES	
69. SIGNATURE OF DECEASED J. J. JONES		70. SIGNATURE OF DECEASED J. J. JONES	
71. SIGNATURE OF DECEASED J. J. JONES		72. SIGNATURE OF DECEASED J. J. JONES	
73. SIGNATURE OF DECEASED J. J. JONES		74. SIGNATURE OF DECEASED J. J. JONES	
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77. SIGNATURE OF DECEASED J. J. JONES		78. SIGNATURE OF DECEASED J. J. JONES	
79. SIGNATURE OF DECEASED J. J. JONES		80. SIGNATURE OF DECEASED J. J. JONES	
81. SIGNATURE OF DECEASED J. J. JONES		82. SIGNATURE OF DECEASED J. J. JONES	
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87. SIGNATURE OF DECEASED J. J. JONES		88. SIGNATURE OF DECEASED J. J. JONES	
89. SIGNATURE OF DECEASED J. J. JONES		90. SIGNATURE OF DECEASED J. J. JONES	
91. SIGNATURE OF DECEASED J. J. JONES		92. SIGNATURE OF DECEASED J. J. JONES	
93. SIGNATURE OF DECEASED J. J. JONES		94. SIGNATURE OF DECEASED J. J. JONES	
95. SIGNATURE OF DECEASED J. J. JONES		96. SIGNATURE OF DECEASED J. J. JONES	
97. SIGNATURE OF DECEASED J. J. JONES		98. SIGNATURE OF DECEASED J. J. JONES	
99. SIGNATURE OF DECEASED J. J. JONES		100. SIGNATURE OF DECEASED J. J. JONES	

RECEIVED  
JUL 2 1957  
BUREAU V. 3



07794

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. LENGTH OF STAY IN 1b <b>11 Days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine X0</b>				d. STREET ADDRESS <b>/</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>Toye</b> Last <b>Toye</b>				4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>19 57</b>				5. SEX <b>Female</b>				6. COLOR OR RACE <b>Negro</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>March 8, 1905</b>				9. AGE (In years last birthday) <b>52</b> yrs.				IF UNDER 1 YEAR Months <b>52</b> Days <b>21</b> Hours <b>19</b> Min. <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>md</b>				11. BIRTHPLACE (State or foreign country) <b>md</b>				12. CITIZEN OF WHAT COUNTRY? <b>md</b>				13. FATHER'S NAME <b>Emerson Bank</b>				14. MOTHER'S MAIDEN NAME <b>Emeline Smith</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>0</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT <b>Paul D. Toye Brandywine md</b> Address <b>md</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Overseas malignancy</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)				INTERVAL BETWEEN ONSET AND DEATH															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Hour <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																			
21. I certify that I attended the deceased from <b>7-11</b> , 19 <b>57</b> , to <b>7-21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7-21</b> , 19 <b>57</b> , and that death occurred at <b>2:00 P</b> M, from the causes and on the date stated above.																															
ACTUAL SIGNATURE <b>Donald W. Mitchell</b>				M.D. <b>1746 K St NW, Wash DC</b>				ADDRESS (Street, city or town, state)				DATE SIGNED																			
PHYSICIAN'S NAME (Type) <b>Donald W. Mitchell</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7-25-57</b>				22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley cm.</b>				22d. LOCATION (City, town, or county) <b>Aquasco md</b> (State)															
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. S. Nelson</b>				ADDRESS <b>1348 N. Calhoun St</b>				24a. REC'D BY REGISTRAR <b>502-2857</b>				24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

JUL 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral-director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08836

07824

## CERTIFICATE OF DEATH

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY Pr. Georges Co.		2439 Owens Rd., Oxon Hill MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Oxon Hill		d. STREET ADDRESS 2439 Owens Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (CONKLIN) MARION C. TYRRELL		4. DATE OF DEATH Month July		Day 9		Year 19 57	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 11, 1897	
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ornamental Iron Worker		11. BIRTHPLACE (State or foreign country) Lorton, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Tyrrell		14. MOTHER'S MAIDEN NAME Mary Dixon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 578-01-3598	
17. INFORMANT Mrs. Alice E. Tyrrell - wife		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED		ACTUAL SIGNATURE Paul Eanet		M.D.			
PHYSICIAN'S NAME (Type) Paul Eanet							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl.		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. By:		ADDRESS		24a. REC'D BY REGISTRAR AUG 12 1957		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

AUG 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7734

## CERTIFICATE OF DEATH

07816745  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6901 Calverton Drive</u>		d. STREET ADDRESS <u>6901 Calverton</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>A.</u> Last <u>WALKER</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 8, 1878</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Luther Day</u>		14. MOTHER'S MAIDEN NAME <u>Anne Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Ruth Walker Zeller 6901 Calverton Dr.</u>	
17. INFORMANT <u>Ruth Walker Zeller 6901 Calverton Dr.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART F. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 3</u> , 19 <u>57</u> , to <u>July 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>57</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl W. Graeff</u>		ADDRESS (Street, city or town, state) <u>2716 Kirkman Pl. W. Hyattsville, Md.</u>	
DATE SIGNED <u>July 18, 1957</u>			
PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>KEMP TOWN</u>		22d. LOCATION (City, town, or county) (State) <u>Kemp town, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Real 4812 Georgia Ave Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>JUL 22 1957</u>	
ADDRESS <u>4812 Georgia Ave Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>James Levey</u>	



CERTIFICATE OF DEATH

Form with multiple sections for death certificate, including fields for name, date, cause of death, and signature. The form is mostly blank with some faint handwriting.

BUREAU V. 2

JUL 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 of 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07817

07795

## CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	c. LENGTH OF STAY IN 1b <u>55 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS <u>5001 Riverdale Rd</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Catherine Waters</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Nov 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u>15</u> Min.	IF UNDER 24 HRS. Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Alexander Power</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Eliz McDermott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36</u>	
17. INFORMANT <u>Sister Anne Elizabeth Waters</u>		Address <u>2869</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac dilation</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.3 Arthritis deformans</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 15</u> , 19 <u>56</u> to <u>15 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 July</u> , 19 <u>57</u> , and that death occurred at <u>4 p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Mattingly</u>		ADDRESS (Street, city or town, state) <u>2200 R.T. Ave N.E. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas E. Mattingly</u>		DATE SIGNED <u>15 July 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James [illegible]</u>	

WISCONSIN STATE DEPARTMENT OF HEALTH - MADISON, WIS.  
CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
OCCUPATION		EDUCATION	
MARRIAGE		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

RECEIVED  
JUL 18 1957  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## (7735) CERTIFICATE OF DEATH

07818

Reg. Dist. No.

245

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Point Branch Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>John Frederick Weinertner</u>				<b>4. DATE OF DEATH</b> <u>July 6</u> 19 <u>57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9, 1881</u>	
9. AGE (In years, last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Endorser</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Endorser</u>		11. BIRTHPLACE (State or foreign country) <u>Hamburg, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Weinertner</u>	
14. MOTHER'S MAIDEN NAME <u>Not Available</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Nursing Home Records</u>		17. INFORMANT <u>Records</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Generalized</u> <u>150.0</u> DUE TO (c) <u>15 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>150.0</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>July 6, 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 6, 1957</u> , to <u>July 6, 1957</u> , that I last saw the deceased alive on <u>July 6, 1957</u> , and that death occurred at <u>12:57 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitlock</u> M.D.				ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u>			
PHYSICIAN'S NAME (Type) <u>JIM. WHITLOCK</u>				DATE SIGNED <u>7-6-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beltsville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St NW</u>				24a. REC'D BY REGISTRAR <u>James</u> DATE <u>9-1-57</u>			
24b. REGISTRAR'S SIGNATURE <u>James</u>				24c. REGISTRAR'S SIGNATURE			

9 JUL 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07819

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN lb. <u>Headman x2 Hillside</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u> e. STREET ADDRESS <u>11409-50th Ave</u> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Marjorie Pearl Wells</u> First Middle Last <b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>7</u> Year <u>1957</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>March 1, 1940</u> <b>9. AGE</b> (In years last birthday) <u>17</u> yrs. <b>10. UNDER 1 YEAR</b> Months <u>7</u> Days <u>17</u> Hours <u>17</u> Min.	
<b>11a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>skilled laborer</u> <b>11b. KIND OF BUSINESS OR INDUSTRY</b> <u>Shade</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S. &amp;</u>		<b>13. FATHER'S NAME</b> <u>Arthur William Anderson</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Frances Pearl Page</u> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u> <b>17. INFORMANT</b> <u>Jerome O Anderson</u> Address <u>6105-7th St</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO (b) <u>Fracture of base of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>816X</u> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>occupant of auto that collided with another</u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>July 7, 1957</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, hotel, office, bldg., etc.) <u>6501 St</u> <b>20f. (City or town)</b> <u>Maryland Park Pk</u> (County) <u>and</u> (State) <u>MD</u>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u> <b>EXAMINER'S NAME (Type)</b> <u>JAMES I. Boyd</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>July 7, 1957</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>7-10-57</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Edgar Hill Cem.</u> <b>22d. LOCATION</b> (City, town, or county) <u>Southend, Maryland</u> (State) <u>MD</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. W. Chambers</u> Address <u>6. 517-11th St. S. E.</u> <b>24a. REC'D BY REGISTRAR</b> <u>Jul 9 '57</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 9 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07736

## CERTIFICATE OF DEATH

Reg. Dist. No.

07820

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3254-Queensstown Drive				d. STREET ADDRESS 3254-Queensstown Dr.			
3. NAME OF DECEASED First Annie Middle B. Last WHITNEY				4. DATE OF DEATH Month July Day 22 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/29/1896	
9. AGE (In years lost birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife at home		11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Walter Brown				14. MOTHER'S MAIDEN NAME Louise Heller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Walter J. Whitney, Son			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DUE TO (c) DISEASE						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 12-30, 1954 to 7-22, 1957, that I last saw the deceased alive on 7-22, 1957, and that death occurred at 11:30 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE R.C. Kirchner				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) R.C. KIRCHNER				M.D. 6480 N.H. AVE-TAKOMA PARK, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7/25/57		Cedar Hill		Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Valley's Funeral Home, Inc.				ADDRESS Mt. Rainier, Md.		DATE JUL 25 1957 James Leary	

BUREAU V. B.

JUL 25 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07821

Reg. Dist. No. 234

Item 8 FilmG218 8-1-57 et

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Camp Springs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4969 Braddock Road S.E.			d. STREET ADDRESS / 4969 Braddock Road S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Pearl Gustava Willett			4. DATE OF DEATH Month Day Year July 21 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1916 February 8, 1916		9. AGE (In years last birthday) 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman		10b. KIND OF BUSINESS OR INDUSTRY Department Str.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Ernest Moreland		
14. MOTHER'S MAIDEN NAME Bessie Jenkins			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. 284 22 1831			17. INFORMANT Horace E. Willett, same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 974x DUE TO Hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self in garage of home from a roof rafter			
20c. TIME OF INJURY Month, Day, Year Hour, m., p. m. 7/21/57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Camp Spring P.G.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 21, 1957	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF July 24 1957		22c. NAME OF CEMETERY OR CREMATORY St. Johns	
22d. LOCATION (City, town, or county) Wabdo		22e. (State) Md.		22f. REGISTRAR'S SIGNATURE Therese Campbell	
23. FUNERAL DIRECTOR'S SIGNATURE The Horvath Funeral Home		ADDRESS Wabdo Md.		24a. REC'D BY REGISTRAR DATE JUL 26 1957	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JUL 26 1957  
BUREAU V. S.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Switland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
c. LENGTH OF STAY IN 1b <u>3 months</u>				d. STREET ADDRESS <u>709-72 1st St SE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Switland Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mabel M. Williams</u>				4. DATE OF DEATH <u>July 20 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-25-1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Switland</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William B. Smallwood</u>				14. MOTHER'S MAIDEN NAME <u>Katherine D. Duley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>324-188-1111</u>			
17. INFORMANT <u>Fredrick H. Williams</u>				Address <u>324 1/2 Lorraine Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary site - Colon</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/12</u> , 19 <u>57</u> , to <u>7/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/19</u> , 19 <u>57</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>524 1/2 St. Barnabas Temple Hills, Md</u> DATE SIGNED <u>7/20/57</u> ACTUAL SIGNATURE <u>John T. Lynn</u> M.D. PHYSICIAN'S NAME (Type) <u>John T. Lynn</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-22-1957</u>		<u>Redeemer Hills</u>		<u>Switland, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Mattingly</u>				24a. REC'D BY REGISTRAR <u>Jul 23 1957</u>			
ADDRESS <u>131-11th St SE</u>				24b. REGISTRAR'S SIGNATURE <u>Genie Campbell</u>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JUL 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07823

-29

07797

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>LAUREL SANITARIUM</b>		d. STREET ADDRESS <b>08X1.2</b>	
3. NAME OF DECEASED (Type or print) <b>BLANNIE</b> First <b>Wright</b> Last		4. DATE OF DEATH <b>JULY 16 1957</b> Month Day Year	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 3, 1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	9. AGE (In years last birthday) <b>83</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edmond Welch</b>		14. MOTHER'S MAIDEN NAME <b>MARY SWANN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>X</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Chas. E. Wright - Indian Head - Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERAL ARTERIO SCLEROSIS</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>7 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 12, 1957</b> to <b>July 16, 1957</b> , that I last saw the deceased alive on <b>July 15, 1957</b> , and that death occurred at <b>10:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7-1658</b>			
ACTUAL SIGNATURE <b>Jesse C. Coggins</b> M.D.		DATE SIGNED <b>JULY 16 1957</b>	
PHYSICIAN'S NAME (Type) <b>JESSE C. COGGINS</b>		<b>LAUREL - MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 19, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Christ Church cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Wayside Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		24. RECORD BY REGISTRAR <b>JUL 23 1957</b>	
25. REGISTRAR'S SIGNATURE <b>Mellie Brashear</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED: *James W. Wells*  
 SEX: *Male*  
 AGE: *78*  
 DATE OF BIRTH: *May 16, 1887*  
 PLACE OF BIRTH: *Ward, Maryland*  
 OCCUPATION: *Farmer*  
 CAUSE OF DEATH: *Heart Failure*  
 PLACE OF DEATH: *Home*  
 DATE OF DEATH: *June 18, 1957*  
 TIME OF DEATH: *10:30 AM*  
 SIGNATURE OF PHYSICIAN: *[Signature]*  
 SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. 81

JUL 22 1957

RECEIVED

*James W. Wells (Farmer)*  
*Ward, Maryland*  
*June 18, 1957*